

# Sustainability of Idaho's Direct Care Workforce

Office of Performance Evaluations  
Idaho Legislature





**Senator Melissa Wintrow (D) and Representative David M. Cannon (R) cochair the committee.**

## Office of Performance Evaluations

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## Joint Legislative Oversight Committee 2023-24

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## From the director

February 15, 2023

Members

Joint Legislative Oversight Committee

Idaho Legislature

More than 33,000 people with disabilities and older adults in Idaho rely on the direct care workforce at home and in their communities. Direct care workers help with essential daily tasks like eating, getting dressed, and building skills for independent living.

Since private insurance and Medicare only pay for direct care in certain short-term situations, people with chronic or long-term needs often end up relying on Medicaid. According to economists we worked with, the state is creating price ceilings that act as a wage cap for direct care workers.

There is a nationwide shortage of direct care workers, but we found that state policy decisions have contributed to a worse situation in Idaho. The state would need 3,000 more workers to get up to national staffing levels and that number is expected to more than triple over the next decade.

Direct care workers reported being drawn to the field because they like helping people. But high wages offered elsewhere are hard to ignore, especially when direct care is often emotionally and physically taxing. We found a vicious circle of high turnover. As people leave direct care, remaining workers take on more responsibility and feel guilty about not being able to do even more to help the people they support.

Our report outlines several recommendations for the Division of Medicaid to improve their rate-setting process and support other efforts to improve sustainability of Idaho's direct care workforce.



Sincerely,

A handwritten signature in blue ink that reads "Rakesh Mohan". The signature is fluid and cursive.

Rakesh Mohan, Director  
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**Formal responses  
from the Governor,  
the Department of  
Health and Welfare,  
the Idaho Council  
on Developmental  
Disabilities, the  
Idaho Commission  
on Aging, and the  
State Independent  
Living Council are in  
the back of the  
report.**



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# Executive summary



Direct care is an interdisciplinary field that encompasses a wide range of services and supports including teaching, nursing, home maintenance, transportation, dietary support, counseling, occupational therapy, and physical therapy. In Idaho, more than 33,000 people with disabilities and older adults rely on the direct care workforce to maintain a healthy and independent life at home and in their communities.

Concern about the direct care workforce prompted the request for this evaluation. The request described a dire situation where a lack of workers led to declining health, unmet medical and personal care needs, strain on families, and relocation to institutional care. In March 2022, the Joint Legislative Oversight Committee directed our office to evaluate how Idaho can create a sustainable direct care workforce.

We used data from multiple independent sources to answer a series of questions about the direct care workforce.

## **Is there a shortage of direct care workers?**

Yes. We conservatively estimated that Idaho is about 3,000 workers, or 13 percent, short of national staffing levels. The shortfall has slowly grown since 2012. By 2032, the shortfall is expected to grow to 9,500. The shortage was worse in North Idaho and among the counties that border Washington and Oregon. The shortage was also worse in industry settings that were more reliant on Medicaid than in settings that have more diverse funding sources.

## **What is causing the shortage?**

Workers reported that low pay was the main reason they did not intend to keep working in direct care. We conducted a survey of direct care workers and received 782 responses. Direct care workers reported that they were drawn to the field because they wanted to help other people, but that the work was emotionally and physically taxing. The typical nursing assistant

**Medicaid is the primary payer for direct care services and supports.**

**When people need long-term, direct care services they pay out of pocket unless or until they qualify for Medicaid.**

in Idaho received \$14.16 per hour, while other direct care workers received \$11.49 per hour according to 2021 data from the U.S. Bureau of Labor Statistics. A nursing assistant could earn an average hourly wage of \$19.64, a 39 percent increase, by leaving direct care while other types of workers could earn \$15.68, a 36 percent increase.

### **Why is this a policy concern for Idaho?**

Medicaid is the primary payer for direct care supports and services, and Idaho's Medicaid rates do not support sustainable competitive wages for direct care workers. Medicaid creates a price ceiling that acts as a wage cap for direct care workers.

Medicaid became the primary payer of direct care services for two reasons. First, Idaho has a long history of offering state support to older adults and people with disabilities. The state consolidated many of these supports under the Medicaid program. Historically, the state provided direct care in institutional settings such as skilled nursing facilities and intermediate care facilities. Beginning in the 1980s and through today, home- and community-based services were incorporated into Medicaid to improve quality, person-centered care while saving money by providing a less expensive alternative to institutional care.

Second, private insurance plans and Medicare typically do not cover long-term, direct care services though they may cover hospice or short-term supports needed because of an acute medical condition. Supplemental long-term care plans exist in the private market, but these plans are cost-prohibitive for most people. That means when people need long-term, direct care services they typically pay out of pocket unless or until they qualify for Medicaid.

Today, Idaho has designed its program making choice a fundamental element of how Medicaid balances quality with efficient and economical care. For this model to work, people who rely on direct care must be able to choose the correct provider, businesses must be able to retain and recruit the right workers, and the Division of Medicaid must be able to measure access, quality, economy, and efficiency in a way that ensures the system remains in balance.

We found that the Division of Medicaid's rate-setting process is a major driver of the worker shortage and undermines the state's ability to achieve its goals because

- people who rely on direct care often feel that they must settle for lower service quality or care provided in an institution;
- when staffing issues arise, people who rely on direct care services may not have another support person to help which can create troubling and dangerous situations;
- businesses feel they must settle for applicants with fewer qualifications or keep poor-performing workers longer than they would like; and
- workers feel they have no choice but to leave direct care because of low wages.

The division does not have good systems for measuring how rates affect access to care. The division counts complaints and tracks the number of providers, while businesses limit access through waitlists, declining new clients, and providing fewer services.

### **How can the state support a more sustainable direct care workforce?**

The most straightforward strategy the state can employ for a sustainable workforce is to ensure that the rate-setting process supports competitive wages by

- setting wage targets using a composite of similar and competitive occupations,
- adjusting the rates more frequently to keep in alignment with the wage targets, and
- considering region-specific rates to better account for different market drivers across the state.

The Department of Health and Welfare could also support current efforts to make training more accessible and develop a career ladder for direct care workers. Finally, we reemphasize the importance of recommendations made in our 2022 report, *Medicaid Rate Setting*, because this evaluation illustrated the continuing consequences of not having adequate management capacity in the Division of Medicaid.

**The Division of Medicaid's rate-setting process is a major driver of the worker shortage.**

**Medicaid rates should support competitive wages and be adjusted more frequently.**

# 1

## Introduction

Though often overlooked, caregiving is a crucial part of daily life. We all participate in the rituals of feeding, clothing, cleaning, coaching, teaching, healing, protecting, and supporting. We care for ourselves. We care for one another.

Most caregiving is unpaid. However, demographic changes and shifts in our state's economy impact our ability to rely on unpaid care. The need for caregiving has increased because Idaho's population has aged and the number of people with disabilities has grown over the past ten years, as shown in exhibit 1. About one in five adults in the United States provides unpaid care to another adult.<sup>1</sup> These people face added pressure to maintain paid employment as housing costs and inflation rise. A 2020 study by AARP and the National Alliance for Caregiving found that about 61 percent of people who provide unpaid care to adults also had paid employment. They spent between 20–30 hours a week providing unpaid care.<sup>2</sup>

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1. AARP AND NATIONAL ALLIANCE FOR CAREGIVING, CAREGIVING IN THE U.S. at 9 (May 2020).

2. AARP AND NATIONAL ALLIANCE FOR CAREGIVING, CAREGIVING IN THE U.S. 2020: A FOCUSED LOOK AT FAMILY CAREGIVERS OF ADULTS AGE 50+ at 27, 40 (November 2020).



## Exhibit 1

**In Idaho, the number of older adults and people with disabilities grew faster than the workforce.**

Change in Idaho's demographics between 2010 and 2020.

	2010	2020	% Change
Median age	34.6	37.1	7%
People in the workforce	761,970	894,850	17%
Total population	1,570,750	1,847,770	18%
People with a disability	195,750	233,480	19%
People 65 years and older	196,130	301,200	54%

Source: Office of Performance Evaluations' analysis of data from the U.S. Census Bureau and U.S. Bureau of Labor Statistics.

Direct care workers are paid caregivers who assist older adults and people with disabilities with essential, daily tasks. Direct care is complementary to and distinct from other fields, such as mental and physical health and social services. In Idaho, direct care is an interdisciplinary field that is not well-defined. Direct care workers have a variety of job titles, including the following:

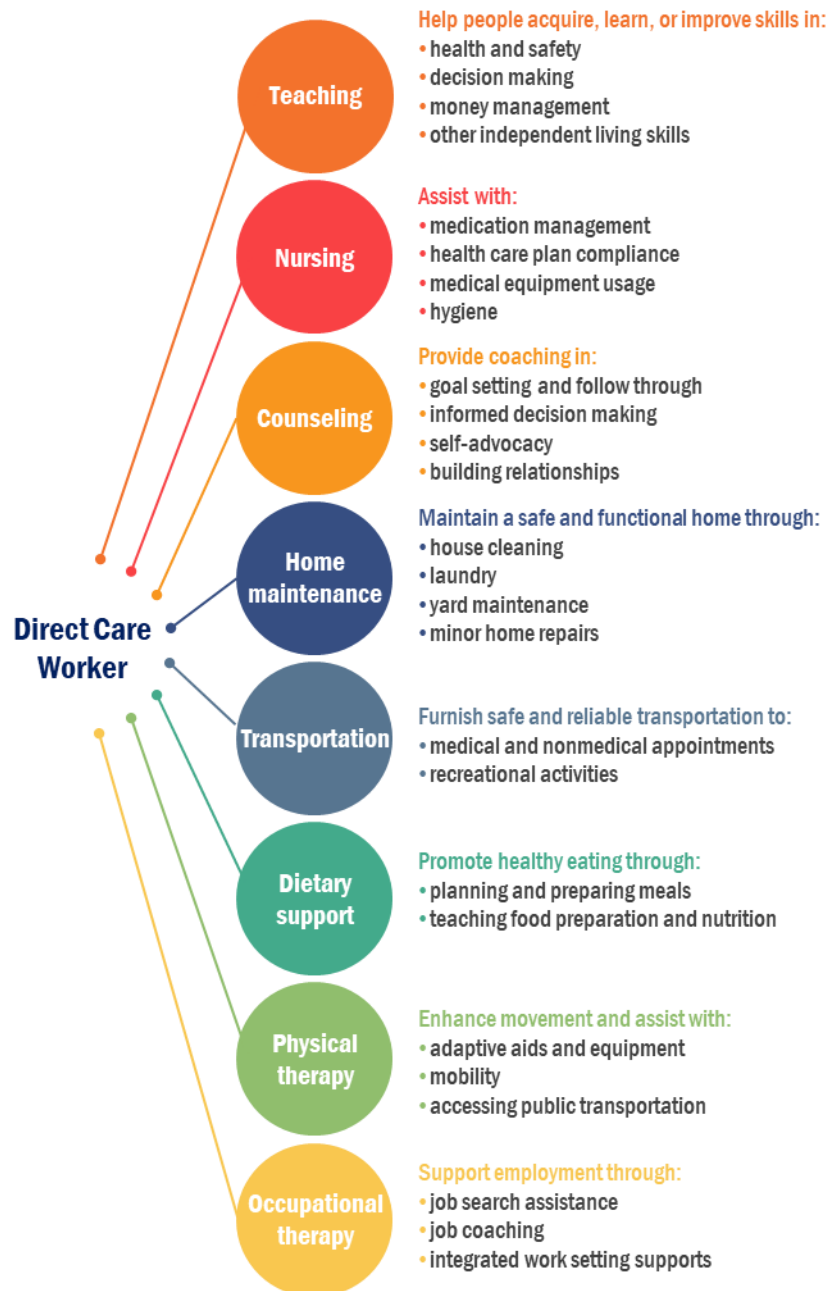
- caregiver, caretaker, care provider, or care support staff
- certified nursing assistant
- community support specialist or worker
- developmental therapist or technician
- direct care professional, provider, or support staff
- direct service professional or staff
- direct support professional or staff
- home health or home care aide
- in-home aide
- personal care assistant, attendant, or provider
- skills instructor or trainer

**Direct care workers assist older adults and people with disabilities with essential, daily tasks.**

## Exhibit 2

### Direct care is an interdisciplinary field.

A wide variety of skill sets and knowledge fall within the scope of direct care.



Source: Office of Performance Evaluations' adaptation from President's Committee for People with Intellectual Disabilities 2017 Report to the President: America's Direct Support Workforce Crisis: Effects on People with Intellectual Disabilities, Families, Communities and the U.S. Economy, Figure 1 at 16, available at [https://acl.gov/sites/default/files/programs/2018-02/2017%20PCPID%20Full%20Report\\_0.PDF](https://acl.gov/sites/default/files/programs/2018-02/2017%20PCPID%20Full%20Report_0.PDF)

## Legislative interest

Concern about the recruitment and retention of direct care workers in home and community settings prompted the request for this evaluation. In March 2022, the Joint Legislative Oversight Committee directed our office to evaluate how our state can create “a sustainable direct care workforce.” The study request described a dire situation in which an insufficient supply of direct care workers resulted in bad outcomes, including strain on families, unmet medical and personal care needs, declining health, and relocation to institutional care. A copy of the study request is in appendix A.

### Who receives direct care?

#### Children with developmental disabilities

**4,670 children with developmental disabilities received direct care services through Medicaid in 2021. More children received school-based services. These children had functional impairments related to a diagnosis of cerebral palsy, epilepsy, autism, intellectual disability, or a similar condition.**

#### Adults with developmental disabilities

**12,660 adults with developmental disabilities received home- and community-based direct care services through Medicaid in 2021. These adults had a functional impairment related to a diagnosis of cerebral palsy, epilepsy, autism, traumatic brain injury, intellectual disability, or a similar condition.**

#### Adults over 65 or who have a disability

**9,780 adults who were over 65, blind, or qualified for disability benefits through the Social Security Act received home- and community-based direct care services through Medicaid in 2021. As a result of their condition, they were assessed to need direct care to remain living at home instead of in a skilled nursing facility.**

**An additional 6,000 adults with a disability received direct care services in a certified family home or assisted living facility through Medicaid in 2021.**

**In total, more than 33,000 people receive direct care services and supports through Medicaid.**

**Medicaid is also the largest payer for direct care services and supports. To qualify for Medicaid, there are individual or family income and asset limits. Depending on how individuals qualify for services and their income, they may need to pay for a portion of their care out-of-pocket.**

## Evaluation approach

Because the direct care workforce is not simply defined, we made the following decisions to align our study most closely with the concerns raised in the study request:

We focused on workers who provide face-to-face services, including

- help with activities of daily living such as eating, bathing, and dressing;

- help with instrumental activities of daily living such as preparing meals, housekeeping, and using the telephone;

- teaching skills that support independent living; and

- unlicensed nursing care, such as monitoring health status, wound care, and medication management.

We focused on home and community settings. Some data sources were not structured in a way that let us filter out care by setting. When possible, we excluded direct care provided in

- nursing facilities,

- hospitals,

- physician's offices,

- outpatient care centers, and

- intermediate care facilities.

We excluded direct care workers in K–12 schools. In the public school system, these employees are classified and generally fall under the title of “paraprofessional.”

Paraprofessionals provide various services, including personal care and educational support. Our 2022 report, *K–12 Classified Employees*, discusses the challenges schools face in recruiting and retaining paraprofessionals and other classified employees.

We focused on long-term services funded by Medicaid since it is the largest payer of direct care. A small share of direct care is funded by state and federal programs that work exclusively with veterans and older adults who do



not qualify for Medicaid. In addition, some short-term services (100 days or less) are covered by Medicare or by private health insurance. We involved stakeholders working with all payment sources throughout the evaluation and incorporated relevant data when possible.

We used a mixed methods approach to answer the following questions:

Is there a gap between the supply and demand of direct care workers?

If there is a gap, why?

How can Idaho better support the direct care workforce?

We used data from multiple, independent sources to compare the results and improve the validity and reliability of our findings. A more detailed scope and list of research questions are in appendix B. An explanation of our methods is in appendix C.

## Report roadmap

The first step in understanding and addressing the challenges facing the direct care workforce is to measure whether there is a shortage of workers. Chapter two reports our findings based on our analysis of U.S. Bureau of Labor Statistics and Idaho Department of Labor data to measure trends in the supply and demand of direct care workers in Idaho. Working with economic consultants from Recon Insight Group, we estimated how many more direct care workers the state would need to match national employment levels.

Chapter three explains why the shortage exists according to the direct care workers we surveyed, interviews we conducted, and other research reports we reviewed.

Chapter four explains the shortage's broader effects on Idahoans, including businesses that provide direct care and people who rely on services.

Chapter five explains why the shortage is a policy concern and describes the impact that Medicaid has on the direct care workforce.

Finally, in chapter six, we present our recommendations to help create a more sustainable direct care workforce.

**Our first step was to determine whether the described shortage existed.**

# 2

## Is there a shortage of direct care workers?

The United States had almost 5 million direct care jobs in 2021, making it the country's largest occupation.<sup>3</sup> Over the next decade, about 12 percent of projected, national job growth will be in direct care.<sup>4</sup> Researchers have attributed the increased demand for paid care to an aging population, changes in the availability of unpaid care, and an increased desire to receive care at home or in the community. The U.S. Bureau of Labor Statistics projects that the country will need to fill an additional 987,000 direct care jobs over the next decade to meet the growing demand and replace workers who leave the occupation.<sup>5</sup>

The supply of direct care workers has been described as a crisis. Medicaid officials in 49 states reported experiencing a scarcity of direct care workers.<sup>6</sup> The problem is particularly acute in Idaho.

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3. BUREAU OF LABOR STATISTICS, EMPLOYMENT BY DETAILED OCCUPATION: 2021 AND PROJECTED 2031, <https://www.bls.gov/emp/tables.htm> (last modified Sept. 8, 2022). Direct service professionals are generally grouped into two occupation categories by the BLS: home health and personal care aides (31-1120) and nursing assistants (31-1131). The total number of workers in these two categories in 2021 was 4.98 million. The next largest occupation was fast food and counter workers with 3.2 million.

4. BUREAU OF LABOR STATISTICS, SUPRA NOTE 1.

5. BUREAU OF LABOR STATISTICS, SUPRA NOTE 1.

6. MOLLY O'MALLEY WATTS, ALICE BURNS, & MEGHANA AMMULA, ONGOING IMPACTS OF THE PANDEMIC ON MEDICAID HOME & COMMUNITY-BASED SERVICES (HCBS) PROGRAMS: FINDINGS FROM A 50 STATE SURVEY, KAISER FAMILY FOUNDATION (Nov. 28, 2022) <https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/> (last visited Dec. 21, 2022). All reporting states (49) reported workforce shortages. One state, Virginia, did not respond to this survey question.

## Idaho does not have enough direct care workers.

Idaho had about 23,000 direct care jobs in home, community, and institutional settings in 2022. We found that our state would need to fill 3,000 more direct care jobs to be comparable to national staffing levels, as shown in exhibit 3. For the purposes of our analysis, staffing levels are a composite measure of the gap between supply of direct care jobs and demand.<sup>7</sup>

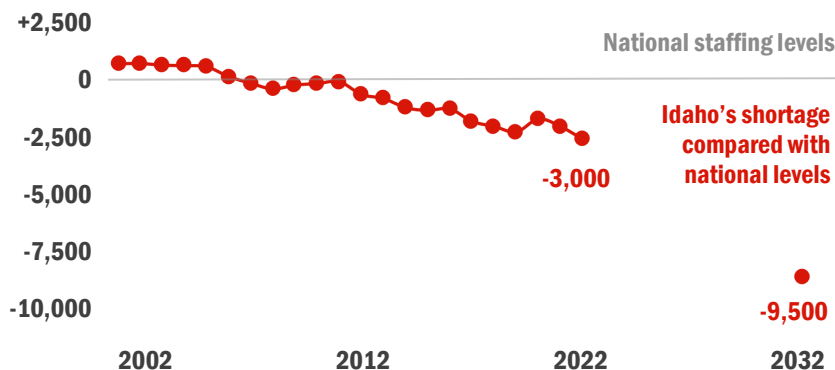
Idaho had more direct care workers than national levels in the early 2000s but began falling behind in 2006. If demographic and workforce trends continue, we estimate that by 2032 Idaho will need more than 9,500 new direct care jobs to reach national levels. National comparisons provide a useful but conservative estimate because a shortage of direct care workers has been documented across the country.

**National staffing levels reflect a shortage of direct care workers, and Idaho's staffing is below the national average.**

**Exhibit 3**

### The shortage of direct care workers compared with national staffing levels is expected to triple by 2032.

Difference between the number of direct care workers in Idaho and the expected number applying national staffing levels.



Source: Recon Insight Group analysis using data from Lightcast, U.S. Bureau of Labor Statistics, U.S. Census Bureau, and Idaho Department of Health and Welfare.

7. We worked with a regional economic consultant, Recon Insight Group, to develop the statewide estimates of the direct care jobs gap. We used the number of older adults and people with disabilities to control for demand. More information about our analysis can be found in appendix C.

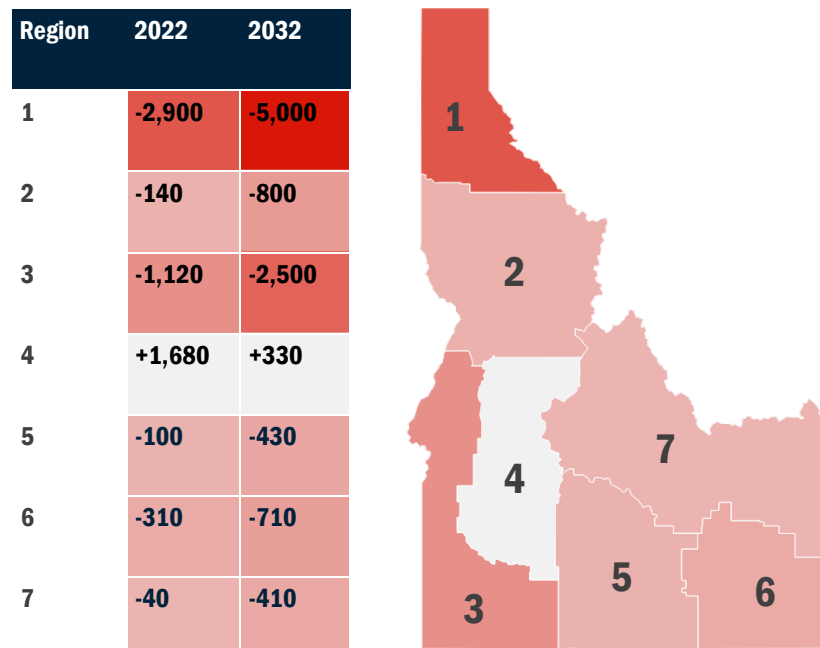
## The shortage is worse for certain regions and services.

North Idaho and counties along the Washington and Oregon border experienced the largest shortage of direct care workers. Exhibit 4 shows that Region 4, which includes Ada County, was the only part of the state with a higher supply of direct care workers than the national levels. If this region were excluded, the state would need more than 4,600 direct care jobs. Region 4's surplus to national staffing levels is expected to shrink by 80 percent over the next decade. At the same time, the shortage of workers is expected to grow in every other region absent any policy changes.

### Exhibit 4

#### North Idaho had the largest staffing shortage and every region is expected to see conditions worsen over the next decade.

Difference between the number of direct care workers by region and the expected number, applying national staffing levels.



Source: Recon Insight Group analysis using data from Lightcast, U.S. Bureau of Labor Statistics, U.S. Census Bureau, and Idaho Department of Health and Welfare.



Another way to assess the workforce gap is to examine the number of jobs by industry or common type of business. Idaho was under-concentrated in two out of three main industries that employ direct care workers compared to national levels. These industries include services provided in homes, communities, and institutions. As shown in exhibit 5, the largest under-concentration of workers was in the industry called “services for the elderly and persons with disabilities.” This industry includes adult day care centers, non-medical home care, homemaker services, group support, and companion care. Services within the industry are often paid for by Medicaid, which we discuss further in chapter 5. The other industries have more diverse funding sources.

#### Exhibit 5

### Idaho had a low concentration of workers in industries with a higher share of services paid by Medicaid.

Direct care workers by industry in Idaho and the state's industrial specialization relative to national levels.

Industry	2022 Direct care jobs in industry	Idaho's concentration of workers in industry compared to national average
Home health care services	8,843	8% higher concentration
Nursing and residential care services	7,858	11% lower concentration
Services for the elderly and persons with disabilities	6,097	45% lower concentration

Notes: Although our evaluation focuses on direct care in people's homes and communities, we also included all institutional settings in this table because industry classifications do not separate intermediate care facilities from other residential care.

Source: Office of Performance Evaluations' and Recon Insight Group analysis of and data from Lightcast and the U.S. Bureau of Labor Statistics.

## More recent data showed a sudden decrease in workers.

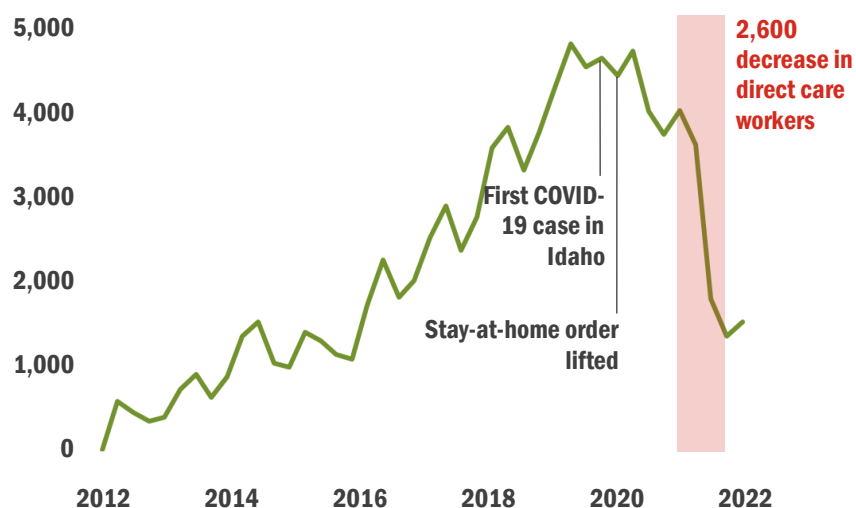
Several people we interviewed reported that recently rising wages in other sectors had attracted direct care workers to jobs in restaurants, retail, and elsewhere. Our estimate of the worker shortage relied in part on U.S. Bureau of Labor Statistics data. This information is reliable in the long run but is not sensitive to sudden changes because it pools data for three years.

To learn more about sudden shifts in direct care employment, we worked with the Idaho Department of Labor to access more frequently collected data. Most employers must report their employees' quarterly wage records to the department as part of filing for unemployment insurance taxes. We analyzed quarterly wage records from January 2012 through July 2022 for nonprofit and for-profit businesses that received payment from Medicaid for direct care services (see exhibit 6).

### Exhibit 6

## The number of employees working for direct care businesses that rely on Medicaid fell sharply in 2021.

Cumulative change in the number of employees of direct care businesses that rely on Medicaid in Idaho since 2012.



Source: Office of Performance Evaluations' analysis of data from the Division of Medicaid and Idaho Department of Labor.

We found that the number of workers employed had been slowly growing until the trend was sharply disrupted in the second half of 2021, when there were 2,642 fewer employees than the peak in 2020.<sup>8</sup> We ran several calculations to see if there was a connection between the timing of the drop in employees and changes in the labor market wages or changes in the demand for direct care. The analysis was inconclusive. We can say that if the drop in employees was connected to people refusing services out of concern about COVID-19, we would have expected to see the change in the second half of 2020 and not a year later.



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8. To target our analysis, we focused on employers that received Medicaid payments that were larger than 50 percent of the total reported salaries. For more information about the importance of Medicaid in direct care, see chapter 5.

# 3

## What is causing the shortage?

In early 2021, the Center on Disabilities and Human Development at the University of Idaho surveyed direct care workers to learn more about the workforce. The center found that low pay, limited benefits, and staff turnover contributed to workforce challenges. Although the researchers raised concerns about the generalizability of their survey due to its small sample size, their conclusions were supported by results from national reports and other state evaluations.<sup>9</sup>

We conducted an independent survey of direct care workers in September 2022 and received 782 responses. For many workers, low pay and other issues overshadowed the benefits of emotionally fulfilling work.



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9. The center's survey received 238 responses.



## The desire to help other people was not enough to offset low pay and other workplace challenges.

Through our survey, we found that workers were often attracted to direct care because they wanted to help other people. According to workers, direct care is rewarding but emotionally and physically taxing. Many employers did not offer benefits. Some workers were also dissatisfied with limited training and career advancement.

But ultimately, insufficient pay was the biggest factor that led direct care workers to leave the occupation. Workers had the knowledge, skills, and ability to earn more outside of direct care. The resulting high turnover intensified challenging work conditions for those who remained.

**Ultimately, insufficient pay was the biggest factor that led direct care workers to leave.**

### Types of direct care work

Direct care workers have many different responsibilities. We asked workers to indicate which of the following best described their job:

**Direct support professional or community support worker services, such as coaching or skill-building for people with intellectual or developmental disabilities to live more independently in any setting**

**Personal care services, such as help with eating, bathing, homemaking, and other activities essential to health and comfort in any setting**

**Home health services, such as basic wound care, monitoring of health status, and other healthcare services provided in the home**

**Nursing assistant services, such as basic wound care, monitoring of health status, and other healthcare services provided outside a home setting**

Some of our survey questions were only applicable to certain workers. When workers were not asked a question, we noted so in exhibits throughout the chapter. For more information, see appendix C.

**Direct care workers have a higher workplace injury rate than construction workers.**

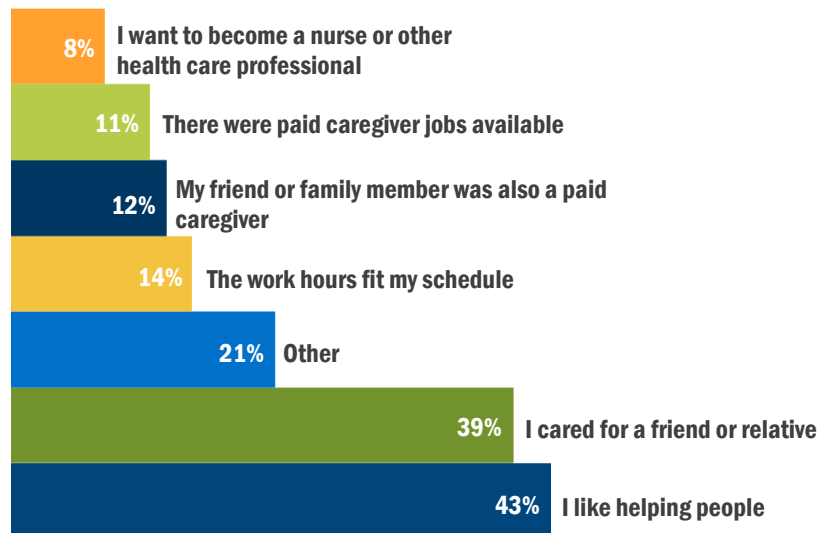
## Rewarding but challenging work

Workers had several reasons for entering direct care. Many started providing direct care to support a friend or relative or because they liked helping people, as shown in exhibit 7. In a separate question that asked what they liked most about their job, 69 percent of workers said that it was the person they supported.

### Exhibit 7

## Many direct care workers decided to become paid caregivers because they like helping people.

Direct care worker response to the survey question: Why did you decide to become a paid caregiver?



Source: Office of Performance Evaluations' analysis of survey data.

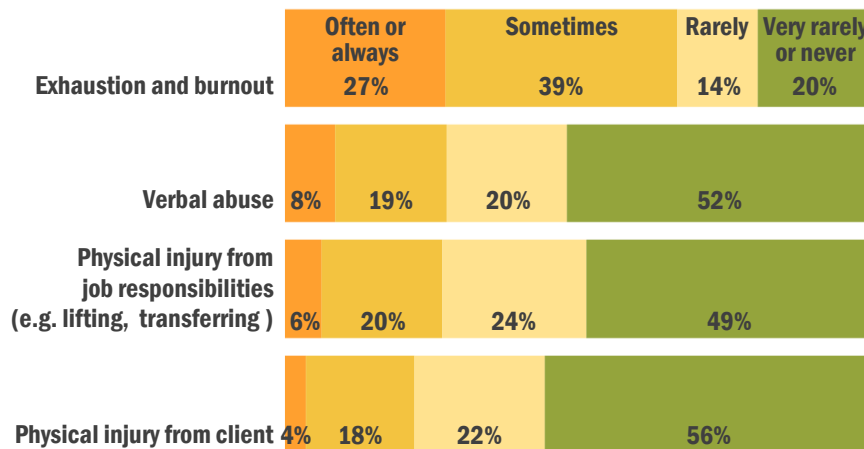
However, direct care work is also challenging and carries some risk. According to the U.S. Department of Labor, direct care workers have a higher than average workplace injury rate and experience more injuries than many occupations known to be high risk, such as firefighting and construction work.

While many of the workers who responded to our survey reported low risk of physical injury at work, more than half reported that it was not uncommon for them to feel unsafe due to exhaustion and burnout (see exhibit 8).

## Exhibit 8

## Direct care workers report a high risk of exhaustion and burnout, and some feel unsafe due to a risk of physical injury and verbal abuse.

Direct care worker response to the survey question: How often do you feel unsafe at your job for the following reasons?



Source: Office of Performance Evaluations' analysis of survey data.

The risk that workers experience depends on the job they do and the needs of the people they serve. Direct support professionals and nursing assistants most frequently reported verbal abuse. Direct support professionals also most frequently reported a risk of physical injury from the people they support. Home health aides most frequently reported feeling unsafe due to a risk of physical injury from their job responsibilities, such as lifting or transferring people. Although many direct care workers often feel safe at their jobs, challenging work conditions can take a toll when they occur.

“ I was getting death threats and being called [names] constantly. Supervisors and management didn't seem willing to do anything, they didn't offer appropriate training for staff for de-escalation or anything. It was exhausting. As soon as I could, I got out.

- Direct care worker who responded to our survey

**8 in 10**  
direct care  
workers reported  
that their  
employer did not  
offer paid sick  
leave.

## Limited training and advancement for some workers

People with disabilities, families, and advocates reported concerns about training and career advancement for workers. We found support for these concerns in parts of the direct care industry. About 35 percent of workers who responded to our survey were dissatisfied with opportunities for career advancement. About 18 percent reported that their training did not prepare them well for their job. When we asked direct care workers about training among their peers, 57 percent reported that most direct care workers in Idaho have too little training.

Limited training and career advancement was a larger concern for direct care workers who

- were not certified nursing assistants;
- worked in homes rather than more institutional and medical settings such as nursing facilities, hospitals, and doctor's offices; and
- cared for children and adults with intellectual and developmental disabilities.

Results of our survey and research from other states indicate that improving training will likely only help recruitment and retention issues if coupled with higher pay.

## Compensation not competitive

Direct care workers often did not have access to paid leave or benefits through their employers, but low wages were their primary concern.

### Paid leave

Almost 6 in 10 workers reported that their employer did not offer paid personal or vacation days. Almost 8 in 10 direct care workers reported that their employer did not offer paid sick leave. Lack of paid sick leave is of particular interest because workers may not be able to afford to miss work given their low wages. This may lead workers to come in when they are sick, putting people who receive services with medical conditions at risk.

## Benefits

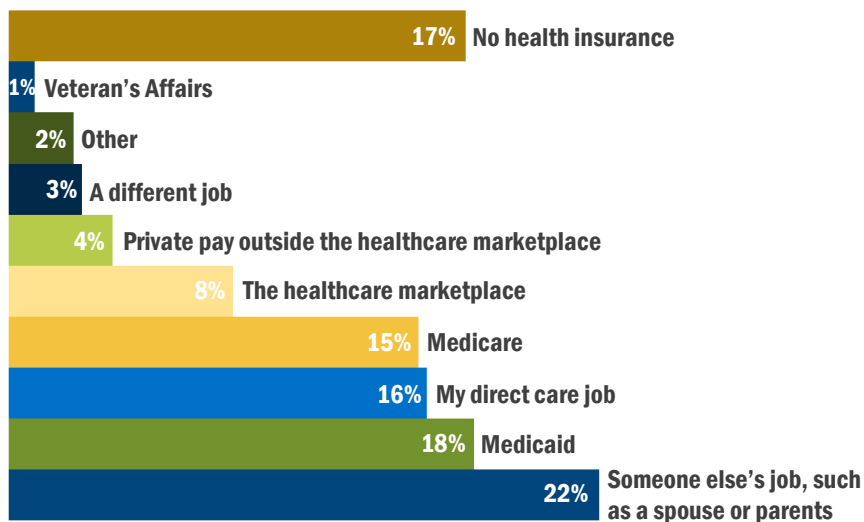
More than 7 in 10 direct care workers reported that their employer did not offer a retirement plan. More than half of workers reported that their employer did not offer health insurance to any direct care workers. More than 6 in 10 reported that they did not qualify for health insurance even if it was offered.

Government-sponsored insurance plans were predominantly used by direct care workers who responded to our survey, see exhibit 9. About 18 percent of direct care workers had health coverage through Medicaid, likely due to the recent expansion of Medicaid to adults with low incomes. National research suggests that 45 percent of direct care workers rely on public assistance, such as Medicaid or food assistance.

### Exhibit 9

## If they had health insurance, direct care workers generally got it through a government program or family member's job.

Direct care worker response to survey questions about their participation in health insurance.



Source: Office of Performance Evaluations' analysis of survey data.

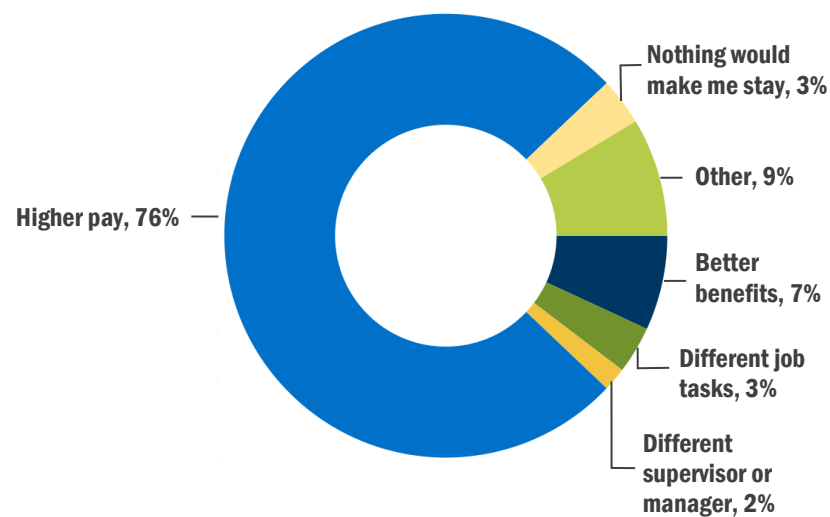
## Wages

Workers who responded to our survey received a wage of \$14 per hour on average.<sup>10</sup> Although many direct care workers wanted benefits, our survey indicated that higher pay was more important. More than 75 percent of direct care workers who were actively looking for a new job said that higher pay was the main thing that would stop them from leaving as shown in exhibit 9. On average, workers said that \$19 per hour would stop them from leaving their jobs at the time of our survey.

### Exhibit 9

## About three quarters of direct care workers reported that higher pay was the main thing that would prevent them from leaving their job.

Direct care worker response to survey question: What is the main thing your employer could do to change your mind about leaving your job?



Note: Certified family homes were not asked this question.

Source: Office of Performance Evaluations' analysis of survey data.

10. This calculation excludes certified family homes, who are usually family members. Certified family homes receive a Medicaid payment that is less than minimum wage.

Nursing assistants in Idaho were paid \$14.16 per hour on average, while other direct care workers were paid \$11.49 per hour, according to the U.S. Bureau of Labor Statistics. Direct care workers had higher wage alternatives to direct care in 2020. We worked with economists to identify comparable jobs outside direct care for which workers would be qualified. The typical nursing assistant could have received \$19.64 by leaving direct care, and other direct care workers could have received \$15.68

These alternative wages had an annual opportunity cost of \$11,398 for nursing assistants and \$8,715 for other direct care workers who chose to remain in the industry.<sup>11</sup> About 23 percent of direct care workers who responded to our survey reported that they would likely leave their job within the next year.

“ Pay is capped at below the average for a fast-food worker. I am changing ostomy bags, cathing, and doing advanced care. I have no opportunity to increase my pay even when the cost of living goes up. I have no sick days. I don't have insurance. I don't make enough to get off Medicaid even working full time.

– Direct care worker who responded to our survey

## High turnover makes work harder

High turnover made the job of those who remained in direct care harder. In August 2022, Idaho's total job opening rate was 7.1 percent as reported by the U.S. Bureau of Labor Statistics. During the same month, the job opening rate for direct care businesses participating in our survey was 20 percent. When we asked direct care workers how insufficient staffing affects their job, they described the following:

- managers had to step in to help
- unpredictable schedules
- too much work
- rushed work
- long hours
- few breaks
- little or no time off

<sup>11</sup>. These calculations were for full-time work.

**Direct care workers could have received a 36-39 percent pay increase by leaving the industry.**



Workers said these conditions led them to experience stress, guilt, poor mental health, exhaustion, and burnout.

“ *It really affects the clients by not having enough staff. They are falling more often, [have] increased depression which has led to decreased mobility and less quality of life. The crisis is terrible right now. It scares me to think of how many seniors are dying alone in their homes and possibly not found for days or longer.*

– Direct care worker who responded to our survey

“ *Many of my coworkers are working overtime every week by at least 2 shifts (16 hours). ... Because of this, many of us cannot take any time off to care for ourselves, our families, or for other personal reasons because there is no one to cover our shifts. Everyone is working as much as they can.*

*Our more observant clients are acutely aware of the staff shortage, and turnover. It is harmful to their sense of self, their sense of safety, and their sense of belongin[g] when it appears no one wants to work with them. Our job can already be challenging for many reasons; not everyone is capable of doing it. Staffing shortages cause an already challenging profession to become that much more challenging for both the staff and the clients.*

– Direct care worker who responded to our survey

# How does the shortage affect Idahoans?

## 4

The direct care workforce shortage affects the 33,000 Idahoans who rely on services and supports through Medicaid, their families and communities, and more than 750 businesses that offer these services and supports. The shortage limits the ability of businesses to implement the most effective business model and people to choose the model of care that is best for them.

A recent survey of 718 direct care businesses across the country found a series of negative consequences stemming from not having enough workers:

- 83 percent of respondents turned away people seeking services

- 63 percent discontinued services

- 55 percent considered additional service cuts

- 92 percent struggled to achieve quality standards<sup>12</sup>

People who rely on services and supports must find a balance of paid and unpaid care that works best for them. Insufficient staffing disrupts this balance. As businesses make difficult choices, people who need direct care are served by less qualified workers, spend more time on waitlists, are turned away, or receive less than their approved level of care. Family members and other unpaid caregivers often act as the backup plan, which risks their ability to earn a living. Not everyone has family available to step in on short notice and people may go without needed care.

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12. AMERICAN NETWORK OF COMMUNITY OPTIONS AND RESOURCES (ANCOR), THE STATE OF AMERICA'S DIRECT SUPPORT WORKFORCE CRISIS 2022, Alexandria, VA: ANCOR, 2022, 2

**For businesses mostly funded by Medicaid, the effects of the shortage were worse.**

## **Businesses that provide direct care have limited choices.**

We surveyed the network of nonprofit and for-profit businesses that provide direct care in Idaho. Of the 142 businesses that responded, 86 percent reported they do not have sufficient personnel to meet the demand for services. Most businesses reported that recruitment and retention of direct care workers was very challenging (see exhibit 10).

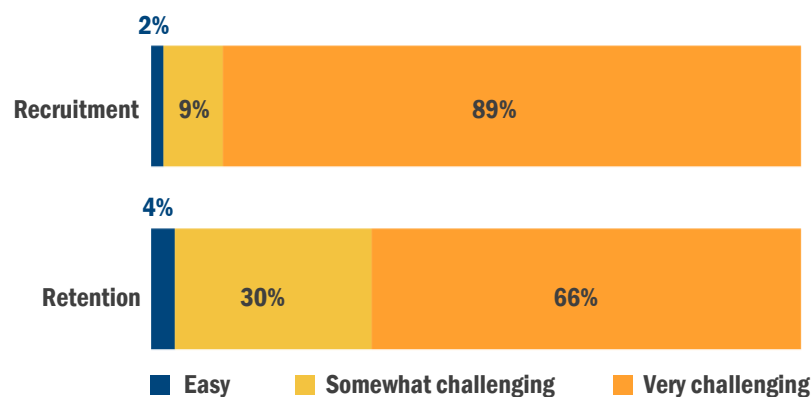
For businesses mostly funded by Medicaid, the effects of the shortage were worse. Those businesses were half as likely to say that they had sufficient personnel when compared with businesses that received most of their revenue from other sources, such as Medicare or private pay. Job opening rates were also higher among businesses that relied mostly on Medicaid.

Businesses reported that payments from Medicaid were insufficient to cover the cost of providing quality care. In response, they reported facing poor choices like hiring employees they would not normally hire, providing less care than needed, and providing lower quality care.

**Exhibit 10**

### **Businesses reported that recruitment and retention of direct care workers was challenging.**

**Direct care business response to the survey question: How challenging is recruitment and retention of direct care workers?**



Source: Office of Performance Evaluations' analysis of survey data.

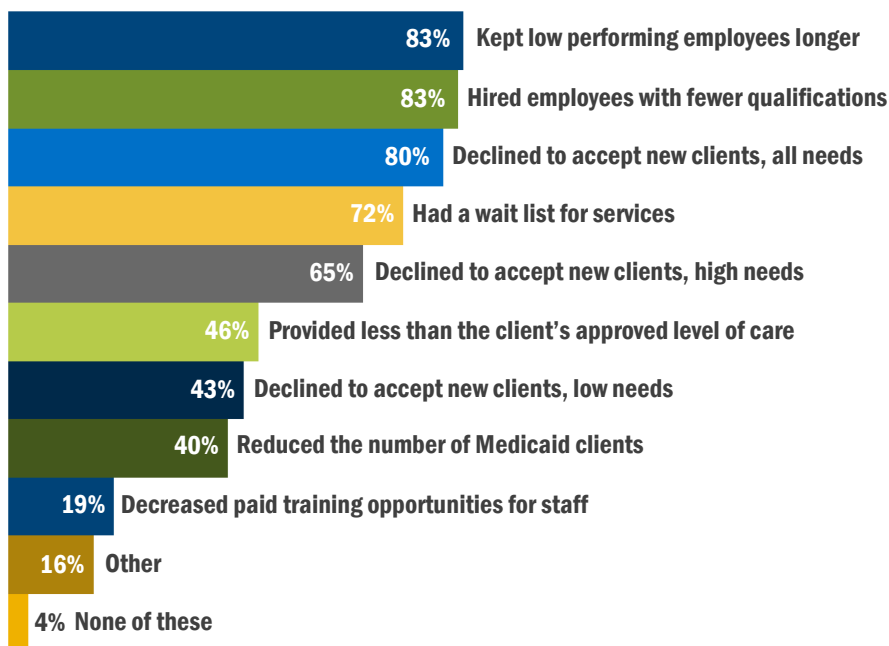
## Having less qualified employees

Since low wages make direct care businesses less competitive in the labor market, they have fewer options when hiring and are more likely to keep an employee who is not a good fit. As shown in exhibit 11, more than 8 in 10 businesses reported hiring employees with fewer qualifications and keeping poor-performing employees longer than they would like. People who receive services and independently hire employees reported similar experiences.

**Exhibit 11**

### Direct care businesses changed their practices because of recruitment and retention issues.

Direct care business response to the survey question: Since January 2022, has your organization had to make any of the following accommodations because of recruitment and retention challenges?



Source: Office of Performance Evaluations' analysis of survey data.

## The importance of a good worker

We asked people who received services (primarily adults with developmental disabilities) two questions: 1) What makes a good direct care worker? and 2) What makes a bad worker?

The responses showed that people most valued being treated with basic human dignity. Responses included the following answers:

- “they show up consistently”
- “are a good communicator”
- “not lazy”
- “compassionate and friendly”
- “has learned about me”

While descriptions of bad workers included concerns about attitude and work ethic, most concerning were the frequent experiences with workers whose behavior was abusive, neglectful, or exploitative. Responses included the following answers:

- “just plays on their phone”
- “ignores me”
- “tries anything sexual since we have a hard time saying no”
- “walks out on me”
- “steals stuff”

We recommended a caregiver misconduct registry in our 2019 report, *Southwest Idaho Treatment Center*, and our 2020 report, *State’s Response to Alzheimer’s Disease and Related Dementias*. Stakeholders and agency officials produced a 2019 whitepaper outlining several paths the state could take to create a registry. However, the Legislature must determine which agency is responsible to develop and implement a registry.

As of the release of this report, Idaho still does not have a caregiver misconduct registry. The Idaho Council on Developmental Disabilities has been working with Boise State University to study ongoing issues with maltreatment of adults with disabilities.

**Less than 1 in 3 surveyed businesses knew that there was a way to report access issues.**

## Limiting access to services and supports

When businesses do not have sufficient staff, they often limit their services. The Division of Medicaid does not have effective measures to determine whether people who need services can access them. The division tracks provider closures and monitors complaints. When we surveyed businesses, we found that less than a third knew that there was a way to report when insufficient staffing affects their ability to provide care.

Our interviews for this evaluation indicated that people may hesitate to file a complaint out of fear that the business or workers will be blamed for systemic staffing issues. Because of an overreliance on self-reported data, the division has inadequate information about access to services and supports.

Our survey revealed that businesses used waitlists, turned away clients, and provided less than the approved level of care.

“ I have clients that have wanted a new worker for years and have gone to multiple agencies only to find that no workers are available. Currently 13 of my 27 clients have hours available that cannot be filled by workers and are thus not receiving services and supports they should be.

– Fiscal intermediary who responded to our survey

### Creating waitlists

Most state Medicaid programs have a waitlist for home- and community-based services. Idaho does not have a formal waitlist for services. However, our survey found that about 7 in 10 direct care businesses had waitlists. In essence, the state's waitlist is pushed down to the level of local businesses. Medicaid enrolls all eligible people who apply for coverage, but people may struggle to find someone who can give them appropriate services and support. The state does not track the extent to which people access their approved services, nor does the state track the reason people do not receive services.

Businesses that receive most of their revenue from Medicaid, like developmental disability agencies and personal care agencies, were almost twice as likely to report having a wait list compared to businesses that receive most of their revenue from other sources. These agencies are the primary providers of services that help older adults and people with disabilities live in their own homes rather than supported residential settings or institutions.

### Turning away people seeking services

Among the businesses that responded to our survey, 80 percent reported that they turned away people seeking services because of staffing challenges. About 40 percent specifically served fewer people who relied on Medicaid. Businesses that rely solely on Medicaid reported trying to reduce unbillable travel time by declining people who needed fewer hours of support or who lived in remote areas. Businesses also reported declining people whose

**7 in 10** direct care businesses that responded to our survey had waitlists.

**8 in 10** responding businesses turned away people seeking services because of staffing challenges.

**Prior rate  
adjustments  
increased the  
amount of care  
people received.**

support needs were complex because the business would need workers with training to serve people with specialized needs. People with complex needs are also more likely to need a lower staff ratio, like one worker to one person, than those with lower assessed needs.

**Providing less than the approved level of care**

Businesses may also continue serving people with disabilities but provide them with less support. Medicaid requires medical and functional assessments to determine whether direct care is necessary and the amount needed for each person. We heard several reports of people receiving less than their approved level of support. For example, a medical professional may assess and determine that a person needs 30 hours of personal care and other supports each week, but a business will only provide 20. In response to staffing issues, 46 percent of businesses reported that they provided less than the approved level of support for the people they serve.

To learn more, we analyzed data provided by the Division of Medicaid's Bureau of Long Term Care.<sup>13</sup> Our analysis confirmed survey and interview findings that the problem was getting worse. Over time, the amount of support people received decreased compared to their assessed level of need.

We also found that a 15 percent Medicaid rate increase in 2018 resulted in people receiving an average of 10 more hours of support each month, indicating that the rate increase allowed businesses to hire more workers and provide more support. A smaller 5 percent rate increase at the start of the pandemic may also have helped retain workers.

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13. The Bureau of Long Term Care conducts assessments for state plan personal care services and the aged and disabled waiver. We were unable to receive sufficient data from the Bureau of Developmental Disabilities for this analysis.



## People who rely on services, and their families, have limited choices.

The direct care staffing crisis leaves people with limited choices in the type and quality of services they receive. Choices look different for each person depending on their needs and circumstances.

People who would like a different direct care worker may settle for lower quality of services and supports because they are unable to find a replacement.

Family caregivers may feel forced to work outside the home and hire a direct care worker.

People who prefer to directly hire and manage their workers may feel forced to go through a private business because high turnover makes it too risky not to have a family member who can afford to step in with short notice.

People with higher needs who prefer to live at home may be unable to find a provider, making them feel forced into more expensive institutional settings.

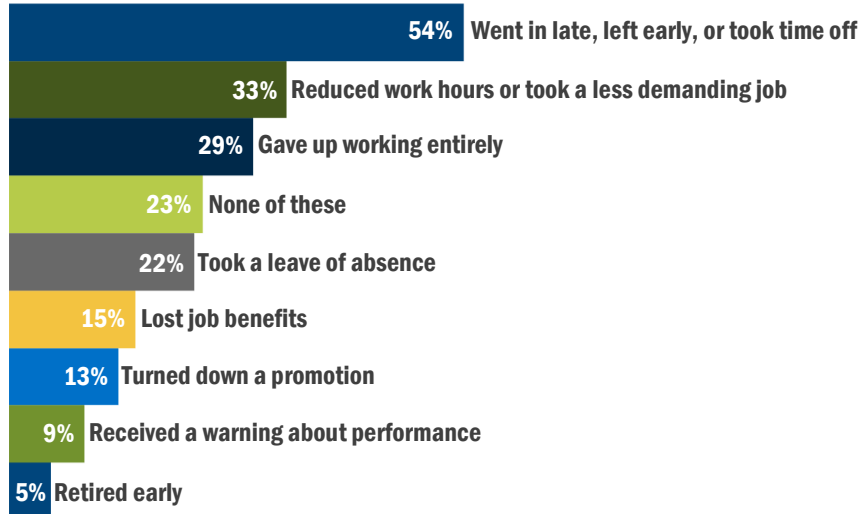
### Stress for families

Family members and other unpaid caregivers often step in to help when a worker does not show up for a shift or similar staffing challenges occur. Our survey and interviews indicated that staffing challenges often affect the ability of family members to earn a living (see exhibit 12).

## Exhibit 12

### Staffing issues affected the ability of family members to earn a living outside the home.

Family caregiver response to the survey question: As a result of caregiving, did you ever experience any of these work-related activities?



Source: Office of Performance Evaluations' analysis of survey data.

Some families find that it is best to keep care in the family and avoid hiring workers, so they structure their lives to do so. Qualified people who live with an adult with disabilities can enroll as a Medicaid provider by going through the process of becoming a certified family home. Certified family home providers act as a critical safety valve for direct care demand in Idaho by covering some costs of families caring for their loved ones.

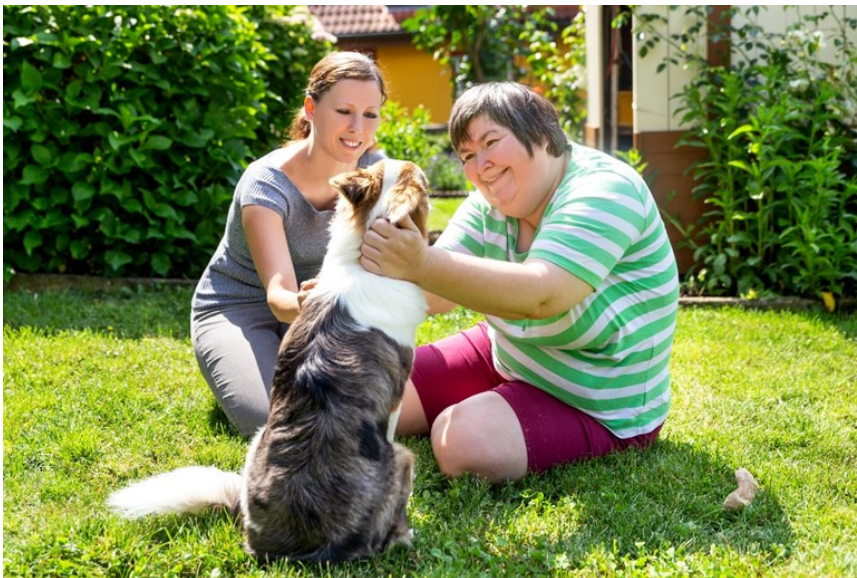
However, they are also subject to the systemic challenges in Medicaid's rate-adjustment process that we identified in our 2022 report, *Medicaid Rate Setting*. The reimbursement rate for certified family homes was last updated in 2008. As a result, many certified family home providers earn less than they would working full time at a minimum wage job outside the home, creating an opportunity cost for families who pursue this option.

## Risks to people who rely on services

People who rely on direct care services do not always have family or other unpaid supports immediately available to help when there are staffing issues, which can create troubling and sometimes dangerous situations. People may feel forced to keep workers who do not show up when they are scheduled, provide poor quality care, or cause other issues. Just over 83 percent of survey respondents who rely on direct care workers reported that it would be very challenging to replace their worker. Among them, 56 percent said that this led them to keep workers longer than they would like.

Workers reported that insufficient staffing resulted in negative experiences for people who rely on direct care including the following examples:

- fewer activities and less time in the community
- distracted or inattentive care
- an insufficient amount of care
- late or missed care
- increased sadness and depression
- more stress and behavioral symptoms
- injuries



**People who rely on direct care reported settling for poor-performing workers because of the staffing crisis.**

# 5

## Why is the shortage a state policy concern?

Idaho's Medicaid rates and rate-setting process are major drivers of the direct care worker shortage. Many businesses rely on Medicaid as their primary funding source for two reasons: 1) private health insurance does not cover long-term services, and 2) many people who pay out-of-pocket eventually exhaust their resources until they qualify for Medicaid.

Medicaid's rate-setting process has deficiencies that leave businesses in a position where they cannot attract enough workers to meet demand and replace people leaving the occupation. Restricted business choices lead to restricted choices for Idahoans who rely on direct care supports. This becomes a policy issue because the state relies on choice to achieve its goal of ensuring access to quality care that is efficient and economical.



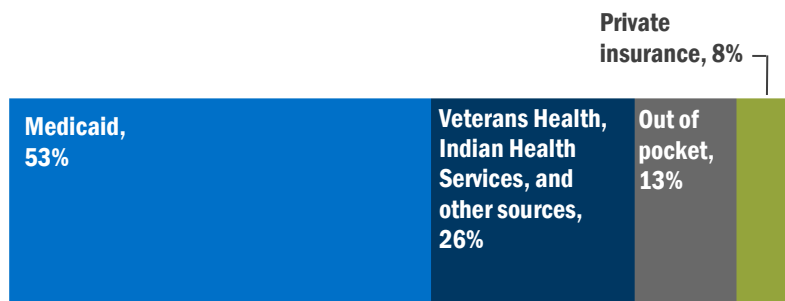
## Medicaid is the primary payer of direct care services.

Medicaid is the largest payer of long-term care nationwide, as shown in exhibit 13. Compared with other long-term care services, Medicaid pays for a larger share of personal care and services for people with intellectual and developmental disabilities. For example, personal care agencies in Idaho reported that 77 percent of their expenses would be paid through Medicaid in the 2017 cost survey conducted by the Division of Medicaid. The University of Kansas Center for Developmental Disabilities estimated that Medicaid paid for 98 percent of services to people with intellectual and developmental disabilities in Idaho in fiscal year 2019.<sup>14</sup>

### Exhibit 13

## Medicaid was the largest payer of long-term care in 2020.

Nationwide spending on long-term care by funding source in 2020.



Source: Kaiser Family Foundation analysis of 2020 National Health Expenditure Accounts.

Medicaid is the primary payer of direct care for three reasons. First, private insurance plans and Medicare typically do not cover long-term, direct care services though they may cover hospice or short-term supports needed because of an acute medical condition.

**Private insurance and Medicare cover short stays in nursing homes but not services provided at home or in the community.**

14. UNIVERSITY OF KANSAS CENTER FOR DEVELOPMENTAL DISABILITIES, STATE PROFILES FOR SPENDING DURING FISCAL YEARS 1977–2019, (last visited Dec. 27, 2022 <https://stateofthestates.org/state-profiles/>).

Second, private long-term care insurance policies exist, but few people purchase coverage, and the number of insurance providers that offer policies has decreased over the last two decades. These insurance policies are generally cost prohibitive and purchased by individuals rather than being sponsored by their employers. In 2021, only 1.4 percent of Idahoans had long-term care insurance according to the Idaho Department of Insurance 2021 Health Survey.

Finally, many people begin paying for long-term care out of pocket but eventually spend through their assets. Medicaid then becomes the remaining funding option.





## Idaho has designed its long-term care programs to embody personal choice, self-determination, and dignity.

States have long supported people with disabilities and older adults who would otherwise not have care. A 1948 case from the Supreme Court of Idaho notes that “the granting of aid to its needy aged is a well-recognized obligation of the state and is a governmental function tending to promote the public welfare.”<sup>15</sup> After Congress created Medicaid in 1965, Idaho organized many of its long-term care programs under the administration of Medicaid.

In the first half of the twentieth century, states usually provided long-term care in institutions. Medicaid initially kept this model of care by paying for state-run or private nursing and intermediate care facilities. In 1981, Medicaid changed its model by providing in-home, direct care services for eligible Idahoans, particularly for adults over 65 and people with physical, intellectual, or developmental disabilities. The state’s current Medicaid plan emphasizes the values of personal choice, independence, self-determination, privacy, and dignity.<sup>16</sup> These values are reflected by providing people with the option to receive services in their homes or community.

Since caring for someone in an institution is expensive, providing home- and community-based services aligns with the state’s goal of being fiscally responsible. In 1981, 61 percent of Idaho’s total Medicaid expenses were for long-term care in an institutional setting. As people began to use home- and community-based services more than institutions, long-term care took up a smaller share of the state’s Medicaid budget. By 2019, long-term care made up just 38 percent of overall Medicaid spending, as shown in exhibit 14.

**Home- and community-based services are less expensive than institutional care.**

15. STATE EX REL. NIELSON V. LINDSTROM, 68 IDAHO 226 (1948).

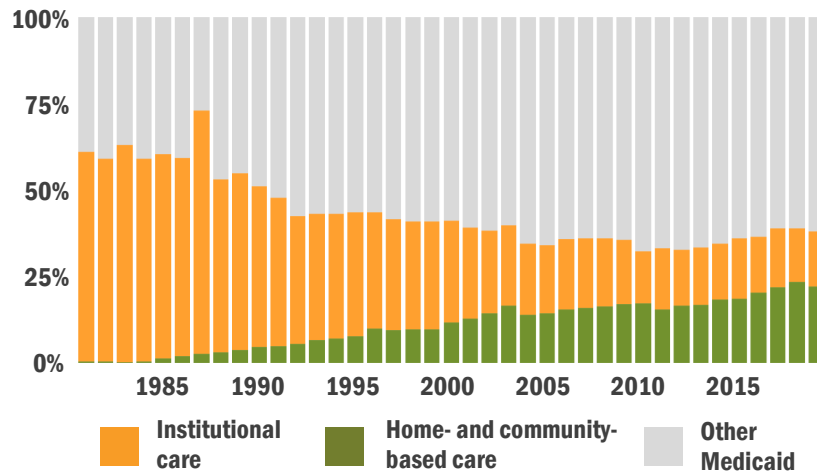
16. IDAHO CODE §§ 39-5601, 56-251(2)(A)-(B), 56-255



#### Exhibit 14

### As Idaho relied more on home- and community-based services than institutions, long-term care was a smaller share of the Medicaid budget.

Institutional care versus home- and community-based services as a share of Idaho's Medicaid budget over time.



Source: Office of Performance Evaluations' analysis of data from U.S. Department of Health and Human Services.

The shift to more home- and community-based services decentralized long-term care and led the state to rely more on consumer choice to ensure quality. When most people who needed services were in an institution, the state's ability to achieve its policy goals was largely up to state employees because the institutions were run by the state. Institutions are still subject to strict federal standards.

Now, most people who need direct care are expected to find a private business that meets their needs or hire a care provider directly. For this model to work, payment rates must be sufficient to create meaningful choices. Instead, we found

- workers often feel they have no choice but to leave direct care because of low wages;

- businesses often feel they must settle for applicants with fewer qualifications and keep poor-performing workers longer than they would like; and

- people who need services often feel that they must settle for lower quality of services or care provided in an institution, when they would rather be at home or in their community.

## The rates and rate-setting process were major drivers of the worker shortage.

Idaho's Medicaid rates do not support a competitive wage for most direct care services. Administrative rule lays out the general framework of rate development, using a target wage with adjustments for overhead costs, including employee-related expenses, program-related expenses, and general and administrative costs.

By rule, rates are set every five years with some possibility to be updated if the division determines it is necessary. However, as soon as a target wage is set into the Medicaid rate, it ages and is less likely to reflect competitive pay as intended. To see this effect, we sampled a set of direct care service rates. We referenced the wage targets from the most recent cost surveys and compared the wages supported by the rates to the wage targets from 2017 through 2022. The hourly target wages and supported wages are reported in exhibit 15.

We found that hourly wages supported by rates were often closer to target wages after a cost survey, but tended to drift away over time. Exhibit 16 shows the variance between the hourly wages supported by the rates compared to target wages.

### Four components of Medicaid rates

The division typically sets rates for direct care based on a target wage for workers plus a percentage of overhead. The rate has four components:

- 1) target hourly wage for direct care workers
- 2) employee-related expenses, such as benefits, typically as a percentage of the target hourly wage
- 3) program-related expenses indirectly related to care, such as wages and benefits for professionals who oversee direct care, typically as a percentage of the target hourly wage
- 4) general and administrative costs, related to the operating of the business but not related to client care, typically as a percentage of the target hourly wage.

## Exhibit 15

### The Division of Medicaid uses different sources to set target wages for services.

Medicaid's direct care target wages come from the U.S. Bureau of Labor Statistics (BLS) or from surveys of nursing homes and intermediate care facilities (WAHR).

Services	2017	2018	2019	2020	2021	2022
<b>Aged and Disabled and Associated State Plan Services</b>						
<b>Attendant and personal care</b>						
Target wage: WAHR	\$11.50	\$11.94	\$12.65	\$13.53	\$14.32	\$16.55
Supported wage	\$10.40	\$11.85	\$11.85	\$12.51	\$12.51	\$13.93
<b>Homemaker</b>						
Target wage: WAHR	\$10.39	\$10.89	\$11.06	\$11.75	\$12.37	\$14.03
Supported wage	\$ 9.17	\$10.71	\$10.71	\$11.35	\$11.35	\$12.20
<b>Adult Developmental Disabilities Services</b>						
<b>Adult day health</b>						
Target wage: BLS, recreation workers	\$13.90	\$14.57	\$13.49	\$15.85	\$15.13	\$17.26
Supported wage	\$ 9.27	\$ 9.27	\$ 9.27	\$ 9.27	\$ 9.27	\$17.23
<b>Supportive living</b>						
Target wage: BLS, personal care aides*	\$10.68	\$11.05	\$13.89	\$14.48	\$14.86	\$15.76
Supported wage	\$10.76	\$10.91	\$10.91	\$10.91	\$10.91	\$16.19
<b>Children's Developmental Disabilities Services</b>						
<b>Habilitative supports and crisis intervention technician</b>						
Target wage: BLS, recreation workers	\$13.90	\$14.57	\$13.49	\$15.85	\$15.13	\$17.26
Supported wage	\$ 6.82	\$ 7.20	\$ 9.89	\$ 9.89	\$ 9.89	\$ 9.89

Notes: This table comprises the following billing codes: H2011-HA, H2015, H2015-HA, H2015-TJ, H2016, H2022, S5100, S5125, S5130, and T1019. Supported wages were calculated by taking the rate and subtracting out the overhead costs as described in the relevant cost surveys. The overhead costs include the portion of the rate intended to cover employee, program, general, and administrative expenses.

\* In 2019, the BLS combined personal care aides with home health aides, which led to an increase in the average target wage.

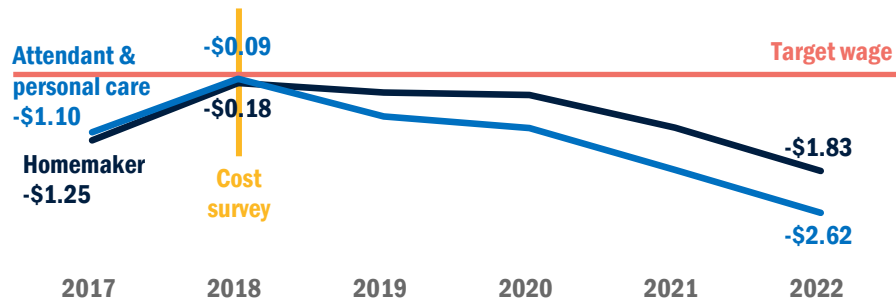
Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare, U.S. Bureau of Labor Statistics, and Myers and Stauffer.

Exhibit 16

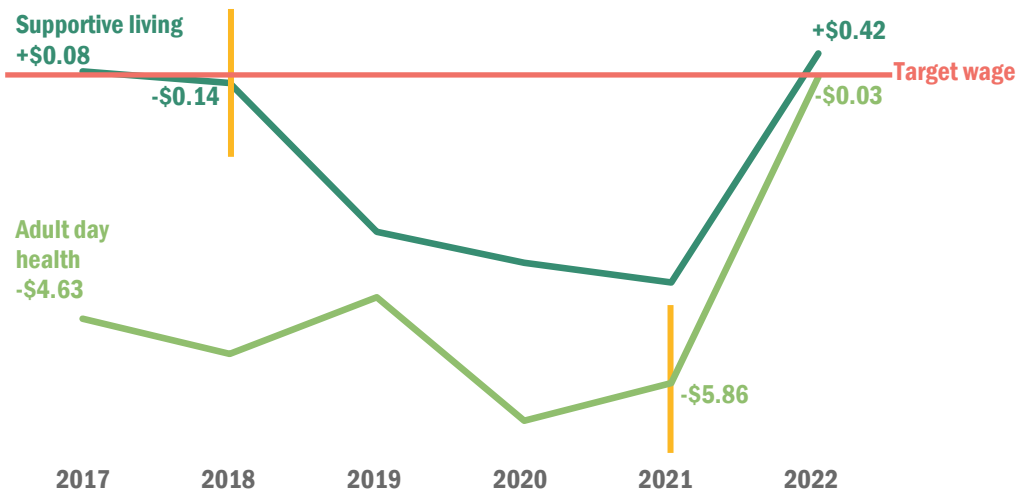
## Hourly wages supported by Medicaid rates were closer to target wages after a cost survey, but drifted over time.

Hourly difference between the Division of Medicaid's target wages and wages actually supported by their rates.

### Aged and Disabled and Associated State Plan Services



### Adult Developmental Disabilities Services



### Children's Developmental Disability Services



Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare, U.S. Bureau of Labor Statistics, and Myers and Stauffer.

The division's goal in setting wage targets is usually to ensure that rates are sufficient to promote a viable business ecosystem. However, both rules and practice are inconsistent between provider types without an apparent policy purpose. In some cases, rule prescribes the method or limit for a rate component. In other cases, Medicaid has discretion. Some examples of inconsistencies include:

For wage benchmarks, most services provided by personal care service agencies have been set using wages calculated from a survey of Idaho's nursing homes and intermediate care facilities. Services from developmental disability or residential habilitation agencies have been set based on occupation codes from the U.S. Bureau of Labor Statistics.

For employee-related expenses, personal care service agencies have rates set based on actual costs from the cost survey while developmental disability services are set using estimates from the U.S. Bureau of Labor Statistics and Internal Revenue Service. This was over a 20-percentage point difference in recent cost surveys (15.85 percent versus 36.86 percent).

Many developmental disability services have a 10-percent cap on the amount of general and administrative costs that can be included in rate development. Other services do not have such a cap.

Certified family home providers often do not try to operate as a small business since they are usually only taking care of their families. Their rates are set differently under each Medicaid program and have not been updated in the developmental disability program since 2008.

## The division's limited management capacity hampers access to care.

People who rely on direct care, their family members, and other stakeholders frequently reported that Medicaid staff were overwhelmed by their caseloads and that officials were often unresponsive.

“ *Everyone goes to work for the department for the right reasons – they care about people. But you get to the point where care gets overwhelmed with work. They've got one person doing five people's jobs.*

– Parent of an adult receiving services from the Bureau of Developmental Disabilities

Our 2022 evaluation, *Medicaid Rate Setting*, found that the division had limited capacity to effectively implement a rate-review process. We further found that the division did not have the information it needed to prioritize rates for review or to know whether rate adjustments had their intended effect, especially on access to care.

In this evaluation, we found that the division continues to struggle to manage or prevent problems that affect the ability of the state to achieve its policy goals. In addition to the findings already discussed, we found that: 1) the division does not have a strategy to address emergent issues with payment and benefit design; 2) support brokers, who are not direct care workers but are required to support people who access direct care through the self-direct model, do not receive adequate support; and 3) language access services are insufficient.

### Payment and benefit design issues

Payment and benefit design choices affect which business strategies are viable and thereby affect people's access to services. For example, covering travel costs in the standard unit rate creates a disadvantage for businesses whose workers travel more than average. This disadvantage may mean that people whose services require more travel per amount of billable time have less access to care.

The division does not have a strategy to address emergent issues related to payment and benefit design. The cost studies, scheduled to occur every five years, represent the perfect opportunity to address these issues such as the following examples:

- how should training costs be incorporated into the program-related expenses component of the rate or should they be billed or reimbursed separately
- how should travel costs be incorporated into the program-related expenses portion of the rate or should they be billed or reimbursed separately
- how should attendant care and homemaker services be billed—separately or as a single service
- should the same rates apply statewide or should there be region-specific rates

For cost studies to effectively address these emergent issues, the division must design the surveys to collect information relevant to the issue and, if possible, pair the cost survey with data on service access or quality. Changes to payment or benefit design would also ideally include strategies to monitor effects on access, quality, and spending.

## Support for those on self-direction

Federal regulations require the state to offer information and assistance to people using the self-directed model. Idaho fulfills this responsibility for people with budget authority through the use of support brokers.

Support brokers are employed by people on the self-directed model, but their job would not exist without Medicaid. Our survey found that although support brokers feel responsible for

### Support brokers

**Some people have authority over their budgets in the self-directed model. People may use those funds to hire their own workers, modify their home, or pursue other things that help them live independently. Support brokers help people create their spending plan, locate resources, develop a back-up plan to handle situations when their worker does not come, and consider ways to terminate workers who are not meeting the people's objectives.**



helping people on the self-directed model with many aspects of Medicaid services, they often do not feel well prepared to do so.

Support brokers also have business costs, such as printing and transportation, which are not tax deductible or paid for by Medicaid. They also face complex tax issues as a result of their role with Medicaid. Support brokers reported that despite repeated requests, they have not received help from the division to address these concerns.

Additionally, older adults and people with physical disabilities do not have budget authority. They also do not have support brokers to help understand service options and assist in accessing services. These services are particularly important for older adults and other people who do not have family or other unpaid supports available. The division eliminated case management in response to cost cutting priorities around the 2008 recession.

## Language interpretation

We heard several reports of difficulties with language access. One example was the way the division provides language interpretation through a phone help line. Sometimes instead of using the language access line, children with developmental disabilities who speak English were relied upon to interpret conversations between their parents who did not speak English and people managing their services and supports. As a result, the children's parents may not have the information necessary to make decisions about care.



# 6

## Recommendations

Reports in every state have documented the challenge of recruiting and retaining enough direct care workers. As a result, states have tried a host of strategies to alleviate the problem.

Some important lessons have emerged as states have wrestled with implementing solutions. First, total compensation—pay, benefits, number of hours worked, bonuses, and reimbursements—matters. While better compensation alone may not be sufficient, it is necessary to improve recruitment and retention.

Second, policymakers and stakeholders must choose strategies that align with the state’s goals and values. No matter how much potential a strategy has on paper, effectiveness will be determined by the collective commitment to good implementation.

Third, implementation requires a long-term collaborative effort among the network of state leaders that affect direct care. In Idaho, these agencies include the following:

- Legislature
- Governor’s Office
- Department of Health and Welfare
- Commission on Aging
- Council on Developmental Disabilities
- State Independent Living Council
- Department of Education
- Division of Veterans Services
- Division of Vocational Rehabilitation
- Division of Career Technical Education

The recommendations in this chapter are intended to address the most immediate causes of the direct care shortage in Idaho.

## Medicaid rates should support competitive wages to achieve a sustainable direct care workforce.

The most straightforward strategy the state can employ for a sustainable workforce is to ensure that the rates support competitive wages. The following four improvements to the rate-setting process would help:

- improve wage targets
- communicate the cost of inflation to the Legislature and adjust rates annually
- incorporate regional rate adjusters
- improve transparency

### We recommend that the division form its wage targets using multiple occupations.

As described in the last chapter, target hourly wages serve as the foundation for Medicaid rates. Idaho rule prescribes two sources for setting wage targets:

- a survey of wages in Idaho skilled nursing and intermediate care facilities<sup>17</sup>
- mean hourly wages for Idaho reported by the U.S. Bureau of Labor Statistics (BLS)

When BLS data informs the wage target, the division selects the occupation profile that most closely aligns with the duties, education level, and supervision requirements of the direct care workers providing the service. The occupation profile is selected with feedback from stakeholders.



17. The survey collects the weighted annual average hourly rate of pay by employment type. The wage target for personal care services is a weighted average of applicable employment types. IDAPA 16.03.10.307.03–04.

The division uses one occupation profile to set rates for most services even though it can use one or more profiles to set the target wage.<sup>18</sup> We identified two drawbacks to using a single profile. First, the BLS does not have individual profiles that align with each Medicaid service. Second, using only one profile may not give robust enough feedback for whether the target wage will be competitive with comparable occupations. For example, we heard reports of rapid wage increases in the food service industry, which attracted workers from direct care. Using a single profile does not give feedback about wage changes in occupations with comparable training and skill requirements. Other states address these limitations by calculating the weighted average of multiple profiles to set wage targets.<sup>19</sup>

We recommend that the division work with stakeholders to develop composite target wages using more than one occupation profile. The goal of the composite target would be to provide a predictable and stable indicator of fair market value for the services being provided. The division should consider including codes from competitive occupations to ensure that the wage targets are not set below the market rate, not just for the specific set of services being provided but also for the training and skill level of workers. The U.S. Department of Labor has a point system for the required knowledge, skills, and abilities by occupation, which could be used to identify competitive occupations.

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18. The default rule is that the division should find a comparable occupation profile, and when there is not comparable profile a weighted average hourly rate is used. IDAPA 16.03.10.037.05(a). For applicable home- and community-based services, including services provided by developmental disability agencies, the target rate is set using the occupation profile that most closely aligns with direct care workers. A weighted average of multiple profiles can be used if more than one profile aligns. If no profiles are comparable, then the survey of skilled nursing facilities and intermediate care facility data is used. IDAPA 16.03.10.038.04.iii—iii.

19. Health Management Associates, Review of States' Approaches to Establishing Wage Assumptions for Direct Support Professionals When Setting I/DD Provider Rates, Prepared for American Network of Community Options and Resources at 7 (July 6, 2022). This study reviewed the rate-setting process of 25 states including Idaho.

## **The Legislature should consider requiring the division to include more information about inflation costs in its budget request.**

Even with well-calibrated wage targets, the current rate-setting process does not have planned and predictable ways to change reimbursement rates between cost surveys. Cost surveys for applicable home- and community-based services are supposed to be performed at least once every five years. Annually, the division reviews provider rates to inform its budget request. The process considers the following factors:

- time since the last rate adjustment for a provider group
- access concerns as captured in Medicaid complaint databases
- patterns of facility closures
- concerns shared by providers during regular meetings with Medicaid staff
- past provider cost survey data
- information on Idaho wages from the U.S. Bureau of Labor Statistics or other data sources
- economic factors such as inflation and state tax revenues

As a result of this process, the division adjusted several rates for direct care services provided after July 1, 2022. Although these considerations are appropriate, we have concerns that the division has insufficient management capacity to implement the process effectively.

Adjusting rates every five years freezes target wages at a single point in time. As we discussed in chapter five, The more time that elapses after a cost survey, the more likely rates are to be insufficient to support competitive wages. In chapter four we described how businesses often limit the services they provide and lower the standards of care to compensate for inadequate rates. The result is cumulative wear and tear in the direct care industry.



The Legislature should consider requiring the division to include a standing line item in its budget request that incorporates the inflationary costs of direct care services. The division already takes a similar approach in its budget request to adjust rates for services tied to Medicare. The request could be based on the wage targets in cost surveys, which are usually updated annually based on BLS data and wages at nursing homes and intermediate care facilities. The Legislature would then be regularly informed about the increased cost of services.

As with all budget requests, the Legislature would retain its authority to approve, amend, or deny the request. However, if the request were approved, the budget would likely stabilize because there would be less dramatic rate adjustments following cost surveys. The division would continue to use cost surveys to rebase and adjust the supplemental component to the rate to account for changes in benefits, taxes, program, and administrative costs.

The Legislature could also consider whether to include statutory intent language that directs businesses to use inflationary increases for wages. Intent language like this was included in H382, passed in the 2021 session, which stated that increases “shall be used solely for temporary pay increases or bonuses for direct care workers.” A 2020 report from the Saint Louis University Research Institute found that 22 states had laws requiring that a flat amount or percentage of reimbursement go to workers.

### **The Legislature should consider allowing the division to set region-specific rates when doing so would address access issues.**

Our estimates of the workforce gap in chapter 2 showed that the gap was not uniform throughout the state. An adequate rate in some communities may be inadequate in others, particularly in communities that border Oregon or Washington where direct care employers receive a much higher Medicaid rate than Idaho pays and therefore can support higher wages.

In *Medicaid Rate Setting*, we recommended that the division’s rate review include a consideration of whether services would be enhanced by allowing region-specific rates. In *Idaho’s Public K-12 Classified Employees*, we suggested the Legislature consider adjusting the state’s financial support to schools based on location. We reiterate these suggestions and emphasize that the regional variation in the workforce gap makes payment for direct care a particularly strong candidate for region-specific rates.



## **We recommend the division improve transparency in setting rates for the self-directed model.**

Policies and procedures that affect worker pay should be transparent. However, we found that the division's policies for setting the fair market control for the self-directed model is not transparent.<sup>20</sup>

The self-directed model is based on the concept of self-determination. The model emphasizes “freedom for the participant to make choices and plan their own life.”<sup>21</sup> People enrolled in the self-directed model have the responsibility to recruit, hire, and train their direct care workers. They may negotiate how much to pay workers so long as three conditions are met: 1) payment “does not exceed prevailing market rate,” 2) payment is “cost-effective when compar[ed] to reasonable alternatives,” and 3) payment does not exceed the approved budget.<sup>22</sup>

People enrolled in the self-directed model submit a plan detailing the workers they will hire and the negotiated pay. The division determines whether the proposed pay complies with rule. Rule does not prescribe how the prevailing market rate is to be determined. The manual that explains how to compile the plan makes only a vague reference to the Idaho Department of Labor as being a good resource in determining a “fair market rate.”

People on the self-directed plan and family members raised concerns that this process goes against the model's goal of ensuring choice. The division reported using several sources to create a fair market rate.

The division should make publicly available what the baseline fair-market rate is, how that rate was calculated, and any additional factors it will use to make the final determination about whether negotiated payments comply with rule for direct care workers and other providers, such as support brokers. Transparency will increase trust among people who rely on services, family members, and advocates and provide the division with an opportunity to incorporate specific feedback.



20. This model is also called consumer-directed or family-directed.

21. IDAPA 16.03.13.010.09.a

22. IDAPA 16.03.13.120.03



## **The Department of Health and Welfare should support efforts to make training more accessible and develop a career ladder for direct care workers.**

Direct care workers support people in different settings and across various programs within and outside of Medicaid. Since direct care workers are not licensed, they do not fall under a uniform training and testing standard. Instead, a worker could be subject to several combinations of initial and ongoing training requirements depending on the setting in which they provide care, their job responsibilities, the needs of the people they work with, and the payment source. Training can also be costly.

The Department of Health and Welfare's Division of Licensing and Certification oversees standards related to the licensure and certification of providers, regardless of revenue source. The division has training publicly available on its website for providers it oversees.

The Division of Medicaid's Bureau of Long Term Care recently received a grant to offer free online training to direct care workers. The bureau aims to create different levels of certification and track when workers have gone through the trainings. A statewide learning management system and career ladder has also been recommended for the Bureau of Developmental Disabilities by their community advisory group, Community Now. Community Now emphasized the need for training to come with wage increases for direct care workers. It has also provided a training plan for direct care workers who support people with intellectual and developmental disabilities. The Bureau of Developmental Disabilities has not yet made any decisions regarding Community Now's recommendations.

**We recommend that the department expand existing efforts to make training more accessible and develop a career ladder for direct care workers.**

Direct care workers and businesses may benefit most from a learning management system with courses that meet the training requirements for the Division of Medicaid's programs as well as the Division of Licensing and Certification's standards. The department could consider treating efforts by the Bureau of Long Term Care as a pilot for expansion to eventually include training standards from the Bureau of Developmental Disabilities and Division of Licensing and Certification.





## **The Division of Medicaid must improve its capacity to manage a program of its size and complexity.**

In our 2022 evaluation, *Medicaid Rate Setting*, we found a long-standing deficit in the management capacity to effectively implement the Legislature's policy in a complex and expensive program. We recommended that the division identify its most urgent staffing needs and include a budget request for the 2024 legislative session.

The division did not request funding for staff in its FY2024 budget. This evaluation revealed the continuing consequences of not having adequate management.

### **We reemphasize the importance of our 2022 recommendations for the Division of Medicaid.**

The division should identify its key management needs and submit a budget request to address those needs. The division should operationalize its measures of access, quality, economy, and efficiency based on Idaho's priorities and embed these measures in the rate-setting process.

## The Legislature could expand access to direct care services outside of Medicaid.

The Commission on Aging and area agencies on aging provide services including housekeeping and caregiving support for family members who need respite. The commission and agencies recently piloted a consumer-directed program in some parts of the state to expand access to care for people of all ages with a significant disability, special need, or chronic illness. The program served 99 people by providing over 3,500 hours of care between September 2021 and February 2022. By allowing families to hire their neighbors and friends, the program brought new people into the direct care workforce to address short-term needs. Consumer-directed respite improved the ability of caregivers to provide care at home and manage stress and burnout, according to a study by Boise State University's Center for the Study of Aging. The Legislature could consider increasing resources for consumer-directed programs for respite and homemaking, or other support services coordinated through the Commission on Aging.



## More strategies could be considered to support direct care workers over the next decade.

Many other strategies have been developed to professionalize direct care, improve data collection, create resource centers, and promote public awareness. Several national advocacy groups have compiled their recommendations for state policy. The following reports may serve as helpful references for long-term discussion about state strategies:

**National Conference of State Legislatures, Supporting Direct Care Workers: Recruitment and Retention Strategies** (Updated April 1, 2022), <https://www.ncsl.org/health/supporting-direct-care-workers-recruitment-and-retention-strategies>

**National Governors Association, State Strategies for Sector Growth and Retention of the Direct Care Health Workforce** (September, 2021), <https://www.nga.org/publications/state-strategies-for-sector-growth-and-retention-of-the-direct-care-health-workforce-2/>

**Milbank Memorial Fund, Direct Care Workforce Policy and Action Guide** (May 18, 2022), <https://www.milbank.org/publications/direct-care-workforce-policy-and-action-guide/>

**PHI, State Policy Strategies for Strengthening the Direct Care Workforce** (April 11, 2022), <https://www.phinational.org/resource/state-policy-strategies-for-strengthening-the-direct-care-workforce/>

**Centers for Medicare and Medicaid Services, National Evaluation of the Demonstration to Improve the Recruitment and Retention of the Direct Service Community Workforce**, prepared by RAND Health (2009), [https://www.rand.org/pubs/technical\\_reports/TR699.html](https://www.rand.org/pubs/technical_reports/TR699.html)





# Request for evaluation



**Sen. Michelle Stennett**



**MICHELLE STENNETT**  
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## Idaho State Senate

### **SENATOR MICHELLE STENNETT** **MINORITY LEADER**

March 10, 2022

#### **Requested study: A sustainable direct care workforce for home and community based service participants**

##### **Background:**

Direct support workers are responsible for the hands-on care for aging adults and people with disabilities. Direct care workers work in a variety of Home and Community Based Service (HCBS) settings. They perform important tasks such as bathing, dressing, housekeeping, meal preparation, medication management, supporting people to learn skills to live and work in their communities, intensive medical care and assistance. This critical workforce provides essential support for seniors and people with disabilities.

The challenges direct care workers face are significant. They are highly underpaid, partly due to the Medicaid reimbursement rates, however there are additional factors that contribute to the long-standing shortage of direct care workers that has been taking place well before the pandemic. There is a deeply rooted undervaluing of the work, long hours, limited training, and often demanding nature of the work. There is a high turnover rate, with many people moving to jobs with fewer hours and benefits. The work they provide is essential. The pandemic has only heightened the urgency to develop strategies that attract new workers to the field and strengthen the direct care workforce.

The lack of staffing also impacts the family's ability to work and is causing a long-term strain on families. Families cannot find staff to help with their children with disabilities. Medically necessary needs go unmet. Many Idaho families, who have been the primary caregivers for their adult sons and daughters, are aging. They are unable to provide the type of support their family member needs.

Individuals with intellectual and developmental disabilities are faced with the reality of having to move from their homes. They are moving to assisted living facilities and nursing homes because there is no staff to provide this in-home support. Assisted living facilities and nursing homes are having the same struggle to hire and keep adequate staff to meet the needs of the residents. The inability to attract and keep needed direct care workers is everywhere. Twenty-seven (27) assisted living facilities have voluntarily surrendered their license, closed a building, or given notice to all Medicaid residents since July 2020. Inability to find adequate staff is the reason cited for the closures. Many assisted living facilities have been forced to limit admissions and even discharge residents because they do not have enough staff to provide the necessary care. Between 2020 and 2022 five (5) developmental disability service providers closed due to staffing issues and low attendance. During this time a total of eighty-one (81) Home and Community Based Service providers closed. Many of these providers were bought out by another agency and some voluntarily closed.

##### **Magnitude of the Problem:**

The average monthly number of members utilizing HCBS services in calendar year 2021 was 15,500, which also includes children receiving services. With this many participants served through the HCBS system, it is imperative that Idaho have a sustainable highly qualified direct care workforce able to meet the complex and essential needs to maintain people's ability to live and work in their home communities.

**Study Objectives:**

- Work with the following HCBS provider types: Independent Living Centers, Assisted Living Centers, Residential Habilitation (Supported Living Agencies and Certified Family Homes), Developmental Disability Agencies, Self-Directed DD Waiver participants, and Community Rehabilitation Providers.
- At the provider level, identify what training is provided? Is it competency based? Is training and demonstrated competency tied to increased pay or benefits?
- How does the Department of Health & Welfare evaluate current direct care workforce staffing levels?
- What are the barriers for direct care staff to sustain long term employment in this service industry?
- What do other states have in place such as a task force to provide strategic planning to tackle the crisis in their HCBS direct care workforce?
- What infrastructure is in place to better understand the current supply and demand of direct care workers?
- Examine policies and procedures used to track data on direct care staffing, including workforce turnover rates, staffing statistics within HCBS settings?
- What training is currently provided to direct care workers in HCBS settings that prepare them to meet the varied complex health and behavioral needs of participants?

**Potential Solutions:**

- What have other states done to incentivize HCBS service providers to participate in additional competency-based training?
- How would the development of a professional career ladder with tiered reimbursement tied to demonstrated competencies post training assist in the creation of a highly qualified sustainable direct care workforce? What are other states' demonstrating with this model?
- Would the HCBS direct care workforce benefit from a direct care registry, increased training and support, the development of career ladders, and a statewide recruitment campaign?

**Recommendation Requests:**

- What recommendations can be learned to assist Idaho in creating a sustainable direct care workforce that is attractive for working long-term in these positions as a career?
- Develop recommendations for proposed legislation, policies, short and long-term strategies for the retention and recruitment of direct care staff to ensure an adequate workforce is in place to provide high quality, cost-effective healthcare.

Respectfully,

*Michelle*

Senator Michelle Stennett  
Senate Minority Leader  
(208) 332-1353



# Evaluation Scope



This study aims to assess the impact of state programs, regulations, policies, and funding decisions on the direct care workforce. We will describe the network of state and private agencies, programs, and job titles that support direct care and answer the following questions:

1. To what extent is there a gap between the needed or approved level of direct care and what is being delivered?
  - a. How many people are receiving direct care through federal or state-funded sources?
  - b. How does the level of services approved compare the level of billed services?
  - c. How are these numbers expected to change over the next ten years?
  - d. What is the current turnover rate for direct care workers?
  - e. How many more direct care positions does Idaho need in the workforce?
  - f. What mechanisms does the state have for monitoring gaps in access and quality of care?
2. What is the impact on individuals, families, workers, agencies, and the state when there is a continuous gap between the needed and delivered level of direct care?
3. What challenges do agencies face in recruiting and retaining staff?
4. What challenges do workers face in entering and remaining in the direct care industry?
5. How can Idaho better support the direct care workforce?





# Methods

## Summary

To gather information for this study, we employed a mixed-methods approach that analyzed data from several independent sources including surveys, interviews, and federal and state agencies. We also conducted a literature review to contextualize our findings and to develop recommendations. Finally, we contracted with RECON Insight Group to conduct an economic analysis to quantify the gap in the direct care workforce, the economic impact of the gap, and the estimated cost to correct the gap.

Our mixed-methods approach reflected the deeply complex system that is direct care in Idaho. Direct care is not a sphere that contains clear distinctions. For example, the U.S. Bureau of Labor Statistics combines the very different jobs of a community support worker helping an individual with developmental disabilities to live in the community, an aide who comes into a person's home to help for a short period of time after surgery, and a person who comes to help an older adult with housekeeping under the occupation Home Health and Personal Care Aides.

Based on the study request, our early interviews with key stakeholders, and our early literature review, we came to narrow our focus to the types of services provided through Idaho's home- and community-based services Medicaid waivers. These services focus on long-term services and supports that help individuals with their activities of daily living so they can stay at home and in the community rather than requiring institutional care. This narrowed focus is nevertheless blurred in many areas. For school-aged children, schools often provide support that combines educational goals and goals for independent living. Schools sometimes contract with employers we have identified as direct care providers, and sometimes bill Medicaid. We chose not to focus on school-based services, but our surveys and data sets may nevertheless include them in an incomplete way.

Similarly, we chose not to focus on short-term care, such as for individuals recovering from surgery. Nevertheless, many workers and businesses who provide short-term care may also provide long-term care.

All of this complexity and difficulty drawing clear distinctions between types of direct care emphasized to us the importance of triangulating evidence from multiple methods to derive our findings.

## Outreach

Direct care services and supports are provided by a loose network of private businesses and workers. When we evaluate a program run by a state agency, we can identify those responsible for implementing the program and have easy access to their contact information. Beneficiaries of the programs we evaluate are often disorganized and require an outreach effort; in this study, both the providers and the beneficiaries of the service required special outreach efforts to get the information we needed to conduct our evaluation.

Reflecting this need for outreach, we created a website dedicated to this project. The site, [opedirectcarestudy.com](http://opedirectcarestudy.com), provided information about our office, the study, and provided an opportunity for direct care workers, people who rely on direct care services, or their families to sign up to be interviewed or to participate in our survey. We shared the site through social media and asked key stakeholders to share the site with their contacts.

## Interviews

We interviewed a variety of individuals and groups, including people who rely on direct care services, advocacy groups, subject-matter experts, and direct care workers. We also visited a developmental disability agency to do job shadowing.

We used a snowball sampling technique to determine who to interview. We started with some key groups representing people receiving services and representing providers and asked them who we should speak to. We asked the same of the subsequent interviewees. We also interviewed individuals who filled out the contact form on our website as independent starting points.

To gather additional perspectives, we held a series of focus groups online, organized by Community NOW! We also had a follow-up focus group with Community NOW!'s Culturally Responsive Advisory Group in Spanish.

In addition to independent individuals, we also interviewed individuals or groups representing organizations, including the following:

Idaho Council on Developmental Disabilities

Idaho State Independent Living Council

Idaho Commission on Aging

Leadership at Idaho Department of Health and Welfare

Idaho Division of Medicaid, Bureau of Long Term Care

Idaho Division of Medicaid, Bureau of Developmental Disabilities

Idaho Division of Licensing and Certification

Idaho Workforce Development Council

Idaho Division of Veterans Services

DisAbility Rights Idaho

Idaho Parents Unlimited

Idaho Federation for Families

Idaho Caregiver Alliance

AARP Idaho

Idaho Association of Community Providers

Idaho Health Care Association

Idaho Continuum of Care Alliance

Idaho Hospital Association

ACCSES-Idaho

Molina Healthcare

centers for independent living

area agencies on aging

direct care businesses

University of Idaho's Center on Disabilities and Human Development

Boise State University's Center for the Study of Aging

PHI

ACLU of Idaho

## Survey

We distributed two surveys to get a broad range of perspectives about direct care in Idaho. We derived our survey questions from several sources, most notably PHI's Arizona Paid Caregiver Survey Instrument used in their report *Insights from the Frontline: Results of a Statewide Survey of Paid Caregivers in Arizona*.

The first survey was tailored to administrators and sent directly to Department of Health and Welfare's main contact for the business. We sent the survey to 784 businesses with valid email addresses. We received 191 responses, 129 of which were complete. We received 39 responses from businesses outside the intended scope of the survey.

The second survey was open to the public, targeted at direct care workers, people who rely on direct care services, their families, and others in the system of care. We distributed the survey to individuals who signed up on our website and through social media. We also contacted several groups we believed to be well connected in the industry and asked for their assistance distributing the survey. These included individual providers, area agencies on aging, support brokers, and advocates representing direct care businesses, people who rely on direct care services, and their families. To encourage participation, we offered five \$50 Visa gift cards. In addition, we organized and delivered a paper Spanish-language survey with postage paid responses to accommodate non-English speakers. We received 1,227 responses to this survey. After removing duplicate responses identified using email and IP addresses, we had 982 responses. About three-quarters of these were from direct care workers.



Another tenth of responses were from people who rely on direct care and unpaid caregivers.

## Limitations

As discussed in chapter 1, the direct care workforce is not a well-defined group of people and we did not have contact information for every worker. We relied on outreach on our website and social media, as well as an extensive network of advocates, government agencies, and providers to distribute our survey to workers. While our response rate was higher than comparable efforts, we nevertheless want to caveat our survey methods.

We did not control messaging that may have been forwarded to workers along with our survey, unless the workers were contacted directly. An unrepresentative sample of workers may have received our survey based on the characteristics or motivations of those we relied on to distribute the survey.

Using a convenience sample also means that we were more easily able to contact certain types of workers. Operators of certified family homes, who we contacted directly, comprise about 10 percent of the direct care workforce but were 37 percent of our direct care worker respondents. Their responses are filtered out when appropriate. Conversely, we had no way of contacting the employer of workers who were directly employed by people who rely on direct care services and the perspective of those workers is likely underrepresented.

## Literature review

To contextualize our findings and develop recommendations, we conducted a literature review of over 80 reports published by agencies in other states about the direct care workforce. We also reviewed reports published by the National Association of Direct Support Professionals, the Medicaid and Children's Health Insurance Program Payment and Access Commission, PHI, Centers for Medicare and Medicaid Services, and the RAND Corporation.

## Economic analysis

We hired RECON Insight Group, which included two economists with the University of Idaho and Washington State University, to conduct an economic analysis. We sought to understand

- whether labor market data indicated the existence of a gap in the direct care workforce, relative to expectations;

- the size of the gap in terms of missing jobs; and

- the cost for Medicaid to fill the gap and the economic impact of doing so.

The analysis used data from the U.S. Bureau of Labor Statistics, Lightcast, and the American Community Survey from the U.S. Census Bureau to derive the size of the labor market gap and the wages necessary to close the gap. IMPLAN, an input-output model, was then used to derive the economic impact of the gap in terms of direct, indirect, and induced demand.

Our economic analysis estimated the number of direct care jobs needed to reach national staffing ratios given the share of Idahoans who are older adults and people with disabilities. Although we do not expect Idaho to mirror the national labor market more broadly, direct care and other occupations that provide basic public services and health care usually have little variation across states after accounting for demographic differences.

Our economic analysis did not estimate the number of direct care workers needed to meet demand. Since people may not be able to access needed services, we do not have sufficient information to determine the demand for services. Frequently cited national estimates of the shortage are conservative for this reason as well.

## Limitations

It is worth noting a few limitations that affected our estimates. First, national data do not include a unique standardized code for direct care professionals. We used a cross section of industry and occupation codes to hone in on direct care professionals.

Second, the occupation codes also do not consistently capture independent providers who work directly for the individuals receiving services from one state to the next. In the captured data, self-employed workers made up about 10 percent of the occupations we used for our estimates. If these workers were underreported or captured differently in other states, that would impact our comparison of Idaho to the national average.

Third, the occupational codes tend to obscure areas where there may be a heightened need. For example, community support workers, who specialize in working with people with intellectual and developmental disabilities, are comingled with the three codes.

## Other data analysis

We received several data sets from the Division of Medicaid, including 10 years of claims from their Medicaid Management Information System and data from 2016 forward from each of the two managed care organizations for billing codes identified as home- and community- based services. In total, the data consisted of over 30 million rows.

We also received assessments of individuals on the Aged and Disabled Waiver or who received Personal Care Services through the state plan from the Bureau of Long Term Care. These assessments included information on people's living situation, level of need, and authorized units of service.

From the Department of Labor, we obtained ten years of quarterly salary filings by Medicaid providers providing direct care.

We combined all of these data sets into a single database to help answer questions about utilization trends, staffing patterns, the connection between wages and Medicaid rates.

# Responses to the evaluation



**Brad Little,**  
Governor of Idaho



**Dave Jeppesen, Director**  
Idaho Department of Health and Welfare



**Judy Taylor, Director**  
Idaho Commission on Aging



**Christine Pisani, Director**  
Idaho Council on Developmental Disabilities



**Mel Leviton, Director**  
Idaho State Independent Living Council



BRAD LITTLE  
GOVERNOR

February 8, 2023

Rakesh Mohan, Director  
Office of Performance Evaluations  
954 W. Jefferson St.  
Boise, ID 83702

*Via e-mail: [rmohan@ope.idaho.gov](mailto:rmohan@ope.idaho.gov)*

Dear Director Mohan,

Thank you for your office's time and attention researching and making recommendations on Idaho's direct care workforce. The report provides insightful considerations for policy makers on the challenges confronting the state Medicaid program.

Your report highlights one of the top challenges facing Idaho employers – the availability of trained workers to fill important jobs. I was pleased to see your report highlight the number of people attracted to the profession of direct care workforce because they “like helping people.” It gets to the heart of what Idahoans are all about and what makes our state such a good place to live.

During my time as Governor, we have focused on increasing healthcare capacity and made historic investments in education. These investments include bolstering career technical programs such as certified nursing assistants, building up nursing capacity at our colleges and universities, and increasing the number of physicians that train in the state so we can ensure Idahoans are cared for.

However, more work remains to be done. I look forward to working with the Idaho Department of Health and Welfare, various other state agencies, industry stakeholders and policy makers to develop strategies to build out the direct care workforce to adequately care for some of Idaho's most vulnerable citizens while keeping Medicaid costs under control.

Again, thank you for work on this important issue. I am committed to working with stakeholders across the state to improve these critical services.

Sincerely,

A handwritten signature in blue ink, appearing to read "Brad Little", is written over a horizontal line.

Brad Little  
Governor of Idaho



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

OFFICE OF THE DIRECTOR  
450 West State Street, 10<sup>th</sup> Floor  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE 208-334-5500  
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February 7, 2023

Office of Performance Evaluations  
Attn: Rakesh Mohan  
954 W. Jefferson St. Suite 202  
Boise, Idaho 83702

Dear Director Mohan,

I want to thank you and your staff for the time and effort spent on your office's report of the Direct Care Workforce here in Idaho. I greatly value the insight and perspective that OPE brings. This report illustrates well the challenges that exist for Medicaid participants to receive services by qualified staff and for providers to hire and retain staff to adequately serve those in need within their communities.

- We agree that there is a clear shortage of available direct care staff in the state. The Division of Medicaid sees this through data collected and in working with participants, families, and providers. The shortage of providers appears to have increased, particularly in recent years, as indicated by your report.
- Medicaid is the primary payor for long-term care and home and community-based services. This means that reimbursement from the program is critical for providers to successfully hire and retain qualified, direct care staff. We agree there is opportunity to evaluate the rate setting process and frequency by which rates are adjusted. We also acknowledge there may be regional variances which may need to be accounted for to mitigate access disparities.
- While reimbursement is incredibly helpful, we also acknowledge it is not the only factor in ensuring the state has a robust field of skilled direct care staff. We appreciate the recommendations regarding accessible training and career ladder development. The Medicaid Division is already working with stakeholders as part of a strategic initiative to evaluate similar opportunities to improve recruitment and retention of direct care staff.

The Division of Medicaid remains committed to working with the legislature, providers, participants, and other stakeholders to address the direct care workforce crisis facing Idaho. We will continue to evaluate provider reimbursement, training opportunities, and other innovative approaches to address this issue. We look forward to continued collaboration with the Legislature around this work and how to best respond to the needs of Idaho's Medicaid providers and participants.

Thank you again for your time and attention in the review of direct care staffing. These recommendations support important opportunities to improve service delivery and the long-term retention of this critical workforce to serve Idaho's most vulnerable residents.

Sincerely,

A handwritten signature in dark ink, appearing to read "Dave Jeppesen", written in a cursive style.

Dave Jeppesen  
Director





## Idaho Commission on Aging

Brad Little, Governor

Judy B. Taylor, Director

February 2, 2023

The Commission on aging applauds the legislature, and in particular the Joint Legislative Oversight Committee for their interest in this important topic. As always working with the Office of Performance Management was collegial and positive, with our input both acknowledged and distilled into the report.

ICOA was gratified that the success of our consumer directed model for home and community-based services was called out as a cost effective, and high-quality service delivery model that does not rely on the professional direct care workforce. We are currently expanding this program for our caregiver respite, homemaker, chore, and transportation services for older Idahoans across the state.

The Commission on Aging stands poised to help support older and disabled Idahoans to age in their communities with the highest possible quality of life and avoid institutionalization.

Congratulations on a comprehensive and easily understandable analysis of this complex issue.

A handwritten signature in cursive script that reads "Judy B. Taylor".

Judy B. Taylor

Director

Idaho Commission on Aging



February 3, 2023

Rakesh Mohan, Executive Director  
Office of Performance Evaluation  
954 W Jefferson Street, Suite 202  
Boise, ID 83702

Director Mohan:

The Idaho Council on Developmental Disabilities is grateful to Senator Michelle Stennett for sponsorship of the study: *A sustainable direct care workforce for home and community-based service participants*. The Council would also like to express our appreciation to the members of the Joint Legislative Oversight committee for their support of this study. The committee's support of this study provides recognition of the valuable role the direct care workforce plays in sustaining Idaho's Home and Community Based Services. This critical workforce affords seniors and people with disabilities the ability to live in their homes and engage in their communities at a significant savings to the state.

The Council would like to applaud the extensive efforts of the Office of Performance Evaluations (OPE) research team. The amount of time, attention to detail, and research skills are evident throughout the report. The Council appreciates the extensive outreach efforts undertaken to a broad set of stakeholders to understand an extremely complex and necessary workforce. The Council looks forward to assisting with the work to implement the OPE recommendations. Furthering these recommendations will assist Idaho to provide livable wages, benefits, and the comprehensive training necessary to improve the quality of this essential workforce to better meet the diverse needs and increasing population of seniors and people with disabilities living in Idaho.

With Sincere Gratitude,

A handwritten signature in black ink, appearing to read 'Pisani', is written over the words 'With Sincere Gratitude,'.

Christine Pisani  
Executive Director  
Idaho Council on Developmental Disabilities



120 S Cole Rd (83709)  
P.O. Box 83720  
Boise, Idaho 83720-9601

February 6, 2023

Rakesh Mohan, Executive Director  
Office of Performance Evaluation  
954 W. Jefferson Street, Ste. 202  
Boise, Idaho 83702

Director Mohan:

The Idaho State Independent Living Council (SILC) appreciates Senator Stennett's sponsorship, and the Joint Legislative Oversight Committee's approval for the study: A sustainable direct care workforce for community-based service participants. Through their commitment to serve Idahoans, the committee recognized the importance of the direct care workforce: working people who support Idahoans with disabilities and seniors in their homes while keeping them out of costly and often isolating institutional care. Direct Care Workers are the heartbeat sustaining the lifeline that Home and Community Based Services (HCBS) provide across our communities.

The SILC further appreciates the thorough work of the Office of Performance Evaluations (OPE). Idahoans with disabilities and seniors are as individually unique as our general population, often living in vastly different geographical areas that require a flexible system of services and supports enhancing our communities. As is typical of studies conducted by the OPE, the enormous effort required to engage stakeholders from across Idaho, including people who receive services, service providers, direct care workers and state agencies is to be commended. The resulting report provides exhaustive detail reflective of the team's thorough research and dedication to the Idahoan's we all strive to serve well.

The SILC is ready to assist in moving forward the OPE recommendations to provide livable wages, benefits and training to a workforce integral to our communities. While true that many Idaho businesses are struggling to hire and retain well qualified staff, the direct care workforce ensures that fellow Idahoans and seniors will indeed rise to meet another day from the safety of their own homes in communities enriched by their presence.

Sincerely,

Mel Leviton  
Executive Director  
Idaho State Independent Living Council



